DOCUMENT RESUME

ED 422 134 RC 021 550

AUTHOR	Marshall, Catherine A.; Gotto, George S., IV
TITLE	Vecinos y Rehabilitation (Phase II): Assessing the Needs and Resources of Indigenous People with Disabilities in the Mixteca Region of Oaxaca, Mexico. Final Report. [English Version.]
INSTITUTION	Northern Arizona Univ., Flagstaff. American Indian Rehabilitation Research and Training Center.
SPONS AGENCY	National Inst. on Disability and Rehabilitation Research (ED/OSERS), Washington, DC.
ISBN	ISBN-1-888557-71-0
PUB DATE	1998-00-00
NOTE	161p.; For Phase I report, see ED 409 156.
CONTRACT	H133B30068
AVAILABLE FROM	American Indian Rehabilitation Research and Training Center, P.O. Box 5630, Flagstaff, AZ 86011; phone: 520-523-8130 (specify English or Spanish version).
PUB TYPE	Reports - Evaluative (142) -- Tests/Questionnaires (160)
EDRS PRICE	MF01/PC07 Plus Postage.
DESCRIPTORS	Access to Education; *American Indians; Children; Community Services; *Disabilities; *Educational Needs; Employment; *Employment Problems; Females; Foreign Countries; Indigenous Populations; Males; Mexicans; Needs Assessment; *Rehabilitation; Research Needs; Rural Areas; Rural Urban Differences
IDENTIFIERS	*Access to Services; *Mexico (Oaxaca); Mixtecan (Tribe); Training Needs

ABSTRACT

This report describes the second phase of a project that identified the circumstances and needs of disabled indigenous people in three geographic areas of Oaxaca state, Mexico. Assisted by a Mixteca disabilities consumer organization and an advisory committee of government officials, health care educators, community service providers, and indigenous people with disabilities, U.S. researchers conducted the project to determine the feasibility of research and training projects for disabled indigenous people in remote, rural Mexican communities. The researchers also looked into continuing to develop a program of information exchange between Mexico and the United States involving experts in the field of rehabilitation and Native peoples. A culturally sensitive survey instrument was developed and administered to 140 indigenous adults and children with disabilities in the Mixteca region. Approximately two-thirds of those surveyed were from rural towns and villages; the remaining one-third were from the city of Huajuapan de Leon. Results indicate great need for physical rehabilitation, employment, health care, emotional support, and education. The majority of adult respondents did not receive an income and had no more than an elementary education; most school-age children with disabilities had no education. All respondents reported no access to local resources or services that could help them with their disability. Even though the majority from each subgroup was unemployed, urban dwellers and men reported higher rates of employment. These findings helped a local grassroots organization to secure funding for the initial steps in development of a comprehensive rehabilitation program. Appendices include graphics illustrating an integrated rehabilitation center,

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a map of the Mixteca region, the survey instrument, advisory committee letters of support, a congress agenda, three presentations, and a summary of roundtable discussions and recommendations at the First Congress Regarding Disability in the Mixteca (August 1996). (TD)

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Vecinos y Rehabilitation (Phase II): Assessing the Needs and Resources of Indigenous People with Disabilities in the Mixteca Region of Oaxaca, Mexico

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Final Report

1998

[English Version]

Principal Investigator: Catherine A. Marshall, Ph.D., CRC

Co-Investigator: George S. Gotto, IV, M.A.

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Funded by the National Institute on Disability and Rehabilitation Research (NIDRR)
Office of Special Education and Rehabilitation Services, U.S. Department of Education, Washington D.C.
Grant No. H133B30068

The contents of this report are the responsibility of the American Indian Rehabilitation Research and Training Center and no official endorsement by the U.S. Department of Education should be inferred.

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(Project Number R-45)

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ISBN 1-888557-71-0

This report is available in alternate formats by contacting the Institute for Human Development at (520) 523-4791.

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"If you need a name for me, call me John."

John Hockenberry
Moving Violations: War Zones, Wheelchairs, and Declarations of Independence

Acknowledgments

Successful research cannot take place without the support and involvement of key individuals in local communities. Many people working together contributed to making this research project a success. The authors would like to acknowledge the considerable work that the volunteer interviewers put into this project. These were the people who traveled throughout the Mixteca region of Oaxaca to interview indigenous people with disabilities. The interviewers were Aurora Sánchez González, Aurelio Jiménez, and Victalina García López. In addition, we would like to extend many thanks to Leticia Green, who served as the project translator, as well as Joyce García, who assisted us with the transcription and translation of the community meeting proceedings. Thanks also go to Germán Pérez Cruz, Director and Pedro Flores Rey, Director of Services and Programs of the Centro de Rehabilitación Integral, who gave valuable support and advice. The following persons from the Project Advisory Committee and from the Project Support Committee have also contributed their time, energy, resources, and support to the project. We are very much indebted to them.

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Summary

Researchers from the American Indian Rehabilitation Research and Training Center (AIRRTC) have spent over a decade documenting the needs of American Indians with disabilities on a nationwide basis. Due to a supplemental grant which was first awarded to the AIRRTC from the National Institute on Disability and Rehabilitation Research (NIDRR) in September, 1994, researchers had the opportunity to share successful AIRRTC research strategies with indigenous people in Oaxaca, Mexico. The initial project led to the identification of the needs of indigenous people with disabilities in three geographic areas in the state of Oaxaca, Mexico (the *Capital*, the *Mountains*, and the *Coast*).

The subsequent project, entitled "Vecinos y Rehabilitation (Phase II): Assessing the Needs and Resources of Indigenous People with Disabilities in the Mixteca Region of Oaxaca, Mexico," was also funded by a supplemental grant awarded to the AIRRTC from NIDRR. The purpose of this project was to:

1. Establish the feasibility of conducting major research and training projects involving indigenous people with disabilities from **remote, rural** communities in Oaxaca, Mexico.
2. Continue to develop a program of information exchange between Mexico and the United States involving experts in the field of rehabilitation and Native peoples.

To accomplish the objectives of this research effort, researchers from the AIRRTC worked very closely with a grassroots, non-profit organization, the *Asociación de Discapacitados de la Mixteca* [Association of People with Disabilities from the Mixteca], the mission of which is to create solidarity

among people with disabilities in the Mixteca region. The director of the *Asociación*, Ovaldo Galicia García, served as the on-site research coordinator for the research project. The project was based in Huajuapan de León, the capital of the Mixteca region and home of the *Asociación*. Mr. Galicia García is of Mixteca heritage and has long been a grassroots leader among indigenous people with disabilities in the Mixteca region. His knowledge of the Mixteca culture was essential to the success of this project, particularly as regards the development of culturally-sensitive research instrumentation and procedures, as well as culturally-appropriate interpretation of the data. Mr. Galicia García had overall responsibility for the general management of the project in the Mixteca region, as well as primary responsibility for meeting with key government officials, local representatives, and consumer groups in the Mixteca region in order to develop the Project Advisory Committee (PAC).

A total of 140 indigenous people with disabilities in the Mixteca region were surveyed for the project. Approximately two-thirds of those who were surveyed were from rural towns and villages such as Santo Domingo Tonalá, Yetla de Juárez, San Isidro el Naranjo, Tezoatlan, Juquila de León, and San Martín del Río Tezoatlan. The remaining one-third of the survey respondents were from the city of Huajuapan de León. In terms of gender, two-thirds of the survey respondents were male and one-third were female. The majority of the survey respondents were adults. Among all respondents, cerebral palsy, mental retardation, polio, and congenital malformations were the most commonly reported disabilities. Finally, and perhaps most important, both the quantitative and qualitative results demonstrated that among the 140 indigenous participants with disabilities there was a great need

for health care, physical rehabilitation, emotional support, employment, and education.

The results of this survey were presented to Mixteca people with disabilities and their families, social and health care workers, and city and state government officials at a conference which was held in the city of Huajuapan de León on August 5 and 6, 1996. In addition, the results of this project helped the grassroots organization *Asociación de Discapacitados de la Mixteca* to secure funding in order to begin the initial steps of developing a comprehensive rehabilitation program. Part of this support was secured from the municipal government of Huajuapan de León. This study awakened the interest of the state government, which gave a donation to start the first rehabilitation programs through the Association.

Recommendations included the need to aggressively seek opportunities to further the development of a comprehensive rehabilitation program in the Mixteca region; to ensure that rural indigenous people with disabilities, in particular women with disabilities, are provided education, rehabilitation, and employment opportunities; to ensure that support and information for families are provided; and, critically, that children with disabilities have access to the health care, physical rehabilitation, emotional support, and education needs which they are currently lacking.

Vecinos y Rehabilitation (Phase II): Assessing the Needs and Resources of Indigenous People with Disabilities in the Mixteca Region of Oaxaca, Mexico

On September 26, 1994, the American Indian Rehabilitation Research and Training Center (AIRRTC) of Northern Arizona University in Flagstaff was awarded its first supplemental grant to conduct research in Mexico. The purpose of the project was to:

1. Establish the feasibility of conducting major research and training projects involving indigenous people with disabilities in Mexico.
2. Initiate a program of information exchange in Mexico involving experts in the field of rehabilitation and Native peoples.

The Rehabilitation Act of 1973, as amended in 1992, states that National Institute on Disability and Rehabilitation Research (NIDRR) funds may be used to "conduct . . . a program for **international** rehabilitation research, demonstration, and training . . ., and initiating a program to exchange experts and technical assistance in the field of rehabilitation of individuals with other nations as a means of increasing the levels of skill of rehabilitation personnel" (emphasis added). Research and training at the AIRRTC are organized around four program Core Areas. **Core Area I** is aimed at identifying and facilitating effective and culturally appropriate rehabilitation services for indigenous people with disabilities. Two NIDRR priorities addressed in **Core Area I** research and training activities are: (1) Develop, demonstrate, and evaluate culturally-relevant vocational rehabilitation techniques for use in the development of effective services to American

Indians; and (2) Develop models to improve rehabilitation and independent living services for American Indians with disabilities. The initial research project, *Vecinos y (Neighbors and) Rehabilitation* (Marshall, Gotto, Pérez Cruz, Flores Rey, & García Juárez, 1996), as well as the current project, *Vecinos y Rehabilitation: Phase II,* have allowed AIRRTC researchers to address these priorities.

Through working with the Oaxaca-based *Acceso Libre* [Free Access] staff, who are both indigenous and persons with disabilities, AIRRTC researchers have received direct input regarding culturally-relevant services needed by indigenous people. Additionally, the research that was carried out by AIRRTC and *Acceso Libre* staff facilitated the creation of *El Centro de Rehabilitación Integral* [Center for Complete Rehabilitation] (see Appendix A), a consumer-initiated and consumer-driven nonprofit organization funded by the W. K. Kellogg Foundation. *El Centro* focuses on the rehabilitation, education, and employment of indigenous persons with disabilities and can provide a model of intervention for indigenous independent living and vocational rehabilitation programs in the United States.

The specific objectives of *El Centro* include: (a) peer counseling as regards physical rehabilitation needs, (b) vocational rehabilitation, (c) development of employment opportunities, (d) family education, (e) disability prevention, and (f) the development of professionals in the rehabilitation field. The purpose of *El Centro* is not only to provide services in Oaxaca City, but to outreach to rural communities throughout the State of Oaxaca as well. The reason for this is that there are currently no such services provided in rural towns throughout the State of Oaxaca. Indigenous persons with disabilities migrate to Oaxaca City in hopes of obtaining some assistance.

However, because there is no affordable housing within the city limits, they are forced to live in separate communities outside the city where they have no services, the living conditions are less than desirable, and they are without their extended family/support network (see Appendix A).

Thus it was proposed that the continuation of the *Vecinos y Rehabilitation* project, in collaboration with *El Centro de Rehabilitación Integral*, would directly benefit the United States by: (1) identifying culturally-relevant vocational rehabilitation techniques that result in effective services to indigenous people with disabilities; (2) providing a specific model of integrated rehabilitation service delivery to indigenous people with disabilities who live in rural, isolated areas, and (3) providing a specific model of integrated rehabilitation service delivery that utilizes minimal economic resources.

Summary of Accomplishments of the Vecinos Project: Phase I

The first objective for the initial research that was carried out by AIRRTC researchers in the state of Oaxaca was to carry out a preliminary assessment of the service delivery needs and resources of indigenous people with disabilities in Oaxaca, Mexico. This objective has been completed; the results of this assessment revealed that there is a great need for rehabilitation, education, and employment services among those surveyed (Marshall, Gotto, Pérez Cruz, Flores Rey, & García Juárez, 1996).

The Needs Assessment

Members of the research team surveyed 232 persons with disabilities from three different geographic regions: the *Capital* (City of Oaxaca), the

Mountains (primarily in or near Miahuatlán), and the *Coast* (primarily in or near Puerto Escondido).

Phase I: Summary of Demographic Results

A large majority [69% (161)] of the respondents came from the *Capital*, 20% (46) came from the *Mountains*, and 11% (25) of the respondents came from the *Coast*. Most of the respondents reported disabilities due to illness [49% (114)]. Accidents were the cause of 32% (75) of the disabilities, and 18% (42) of the disabilities were congenital.

Almost half of the respondents [48% (111)] received a steady income; the majority of respondents [51% (118)] received no personal income. The majority of *Adult* respondents [52% (100)] were gainfully employed; a little over a quarter [27% (53)] were unemployed. Thirteen percent (30) of all respondents classified themselves as students, with 4% (9) of all respondents being pensioners.

In terms of the employment statistic reported above, while the majority of adult respondents were employed, this number included seasonal workers, sustenance farmers [*campesinos*], and part-time workers. According to grassroots leader Ing. Rigoberto Mendoza Bohorques, it is rare to find a person with a disability who has a full-time job with benefits, especially in rural areas (Personal communication, October 26, 1995). Further, while the majority of adult respondents were employed, in actuality, this majority refers only to men with disabilities; just over a third of adult women with disabilities were employed, compared to over 50% of the men.

Over half [57% (131)] of the respondents to the survey either had no education or had only a grade school (primary) education. The data also indicated that the respondents who had a higher level of education had a better chance of being employed. However, despite a high level of education,

those persons who had a professional education still reported an unemployment rate of 16% (4). Those with a high school education reported an unemployment rate of 20% (4).

Phase I: Summary of Results by Geographic Region

The employment rate in each of the three geographic regions was relatively low. However, those respondents who lived in the *Capital* had a higher rate of employment than the respondents from the *Mountains* or the *Coast*. The unemployment rate among the *Adult* respondents from the *Coast* was extremely high at 43% (10).

The majority of the respondents in the *Capital* either had no education [12% (20)] or only had a primary education level [40% (64)]. The same is true in the *Mountains*, where 33% (15) of the respondents had no education and 22% (10) of the respondents only had a primary level education. On the *Coast*, 28% (7) of the respondents had no education and 60% (15) of the respondents had only a primary level education. None of the respondents on the *Coast* had a professional or university education. Only 13% (21) of the people in the *Capital* and 9% (4) of the people in the *Mountains* reported having a professional or university education.

Knowledge and Skills Exchange

The second objective of the initial research was to determine the feasibility of establishing a collaborative, long-range rehabilitation research and training effort in Mexico. The co-coordinators of *Acceso Libre*, who also served as the on-site research co-coordinators of the *Vecinos Project: Phase I*, Germán Pérez Cruz and Pedro Flores Rey, made two trips to the United States to talk with AIRRTC administrators and researchers, as well as to meet with officials from United States organizations that promote equal access for

persons with disabilities. On their second trip to the United States [with funding provided by the United States Information Agency (USIA)], Sr. Pérez Cruz and Sr. Flores Rey were accompanied by Miriam Gabriela García Juárez, President, *Unión de Mujeres Discapacitadas* [Union of Women with Disabilities], Oaxaca, Mexico; Ing. Santiago Barahona Casas, *Director General de Desarrollo Social* [Director of Social Development], Oaxaca City Government; and Dr. Mabel Prado Picón, *Jefe, Oficina de Bienestar* [Director of Social Welfare], Oaxaca City Government. The group traveled to Los Angeles, California; Flagstaff, Arizona; and Phoenix, Arizona, where they visited rehabilitation centers, hospitals, and research centers in order to observe methods of rehabilitation for persons with disabilities.

In addition to these trips to the United States by *Acceso Libre* and Oaxaca City officials, Dr. Catherine A. Marshall of the AIRRTC traveled to Oaxaca to develop a Project Advisory Committee (PAC) that included indigenous people with disabilities, as well as key government officials, health care educators, and community service representatives. At the conclusion of the initial phase of research, PAC members indicated a strong interest in continuing the process of knowledge and skills exchange, and supported the continuation of long-term rehabilitation research, training, and intervention in Oaxaca. Several PAC members have continued to work with and support the efforts of *El Centro de Rehabilitación Integral,* as well as Phase II of *Vecinos y Rehabilitation.*

Assessing Needs in Rural Villages (Vecinos Project: Phase II)

According to a document distributed by the U.S. Department of Education (*Briefing,* 1991), "from its inception, NIDRR has been active in international research of benefit to the U.S. and to other Nations."

Specifically, according to a recent summary of the U.S. role in international rehabilitation (International, 1994):

> Within the last five years, the U.S. Government has once again begun to take a closer look at its responsibilities for sharing information on rehabilitation with other nations. . . . Government and non-governmental agencies are seeking new partnerships--with themselves, with their counterparts from other nations, and with the disability community--to make their planet more accessible and their lives more productive (p. 4).

In both the United States and Mexico, service providers struggle to appropriately serve persons in rural areas, in particular people from indigenous backgrounds. In Mexico, the State of Oaxaca is known for its rich cultural background and traditions carried out by the diverse indigenous peoples who populate the state. The State of Oaxaca "is largely populated by Zapotec and Mixtec Indians who have in large measure retained their individual languages and customs" (*Encyclopedia Americana*, p. 585).

While the indigenous people of Oaxaca have long been studied by anthropologists (see, e.g., Greenberg, 1989; Nolen, 1973; Parsons, 1936), archaeologists (see, e.g., Brockington & Long, 1974; Flannery & Marcus, 1983), and ethnologists (see, e.g., Chance, 1989, Cook & Borah, 1968), the needs of indigenous people have been ignored. Further, the resources of Oaxaca's indigenous people, and the information and skills they would have to share with indigenous people of the United States, have been ignored by rehabilitation educators traveling throughout other parts of the world in their efforts to improve the U.S. public vocational rehabilitation program.

Thus the purpose of *Vecinos y Rehabilitation: Phase II* was to:

1. Establish the feasibility of conducting major research and training projects involving indigenous people with disabilities from **remote, rural** communities in Oaxaca, Mexico.

2. Continue to develop a program of information exchange between Mexico and the United States involving experts in the field of rehabilitation and Native peoples.

METHODOLOGY

Oaxaca, Mexico was selected as the target site for this project due to its large population of indigenous people. A linkage to this state was made initially through Partners of the Americas, a "voluntary organization promoting economic and social development in the western hemisphere, while fostering inter-American friendship and cooperation" (Partners Brochure). The relationship between AIRRTC researchers and the State of Oaxaca was strengthened through the initial research carried out in conjunction with *Acceso Libre* (*Vecinos Project: Phase I*) and through the subsequent development of *El Centro de Rehabilitación Integral*. A complete history of the initial project and description of the research can be found in *Vecinos y rehabilitation: Assessing the needs of indigenous people with disabilities in Mexico* (Marshall, Gotto, Pérez Cruz, Flores Rey, & García Juárez, 1996). The current project has enabled AIRRTC researchers to outreach to **rural and remote** areas in an indigenous region known as *La Mixteca* (see Appendix B).

Research Questions

1. What are the needs of indigenous people with disabilities in **rural and remote** communities in Mexico? What research methodology is best suited to assessing their needs?

2. What specific rehabilitation technologies currently employed successfully in Mexico can be of benefit to American Indians with disabilities, especially those living on rural and remote reservations? To what extent can technologies successfully utilized in the United States by people with disabilities be exported to Mexico?

Participants

The city of Huajuapan de León served as the base for this project for two reasons:

(1) It is centrally located within the Mixteca region.

(2) *Acceso Libre* had established contacts in the area.

There were 140 indigenous people with disabilities from rural communities in the Mixteca, as well as from the town of Huajuapan de León, who responded to the survey. These 140 people represent a "snowball" sample of indigenous people with disabilities, that is, the initial participants were people that the on-site coordinator and volunteers from the *Asociación de Discapacitados de la Mixteca* (ADM) [Association of People with Disabilities from Mixteca] knew. After each interview, the interviewer would ask the respondent if he/she knew anyone else within their own community or a neighboring community who had a disability and who identified as indigenous. The interviewers would then contact the individuals and ask if they were interested in participating. Secondly, interviewers went to a given community, established a community contact (e.g., mayor, priest, teacher), and asked if he/she knew of any indigenous people with disabilities in the

community. Finally, interviewers also approached citizens on the street to ask if they knew anyone with a disability. The procedures for conducting the research are further detailed below.

Instrumentation

The survey instrument that was used for this research project was based on the instrument that had been developed by the research team in the *Vecinos Project: Phase I* (Marshall, Gotto, Pérez Cruz, Flores Rey, & García Juárez, 1996). Because he had worked closely with the *Phase I* data, Mr. Gotto was able to make suggestions regarding improvements to the survey instrument that would lead to more manageable data. Mr. Gotto presented these suggestions to Mr. Galicia García and other members of ADM. Subsequently, further corrections/changes were made to the survey instrument that tailored it specifically to the Mixteca region (see Appendix C).

Procedures

Researchers from the AIRRTC have spent over a decade assessing the needs of American Indians with disabilities on a nationwide basis. For more than five years, AIRRTC research has been focused at the local community level, and has included American Indian people with disabilities throughout the research process--from design, to instrument development, to data collection, to dissemination. This philosophy of directly involving Indian people with disabilities in the research process guided the procedures of this project.

The Principal Investigator (PI), Dr. Catherine A. Marshall, made an initial trip to Huajuapan de León in October, 1995, in order to assess local interest in participating with the AIRRTC research project. It was on this trip that Dr. Marshall met Ovaldo Galicia García, President of the ADM, a grassroots, non-profit organization, the mission of which is to create

solidarity among people with disabilities in the Mixteca. The relationship with Mr. Galicia García and ADM was further solidified in December, 1995, when Mr. Galicia García and other members of ADM attended and participated in a conference in Oaxaca City that was sponsored by the AIRRTC, *Acceso Libre, Dirección General de Desarrollo Social* [General Administration of Social Development], *Frente Unido de Minusvalidos* [United Front of People with Disabilities], and *Unión de Mujeres Discapacitadas* [Union of Women with Disabilities] (Marshall, Gotto, Pérez Cruz, Flores Rey, & García Juárez, 1996). [At this conference, Mr. Galicia García presented a paper entitled "Advances and Social Awareness of the People with Disabilities in the Mixteca region" (see Appendix B in Marshall, Gotto, Pérez Cruz, Flores Rey, & García Juárez, 1996). In this presentation, he discussed the progress that ADM has made in terms of rehabilitation, employment, and education for people with disabilities in the Mixteca.]

On-site research coordinator. After determining that the Mixteca region would be the site for Phase II of the *Vecinos y Rehabilitation* project, the first priority was to hire an indigenous on-site research coordinator. Because of previous contact with Ovaldo Galicia García, because he was the founder and president of ADM, and because he had extensive contacts in the community of people with disabilities, as well as with community leaders and health and rehabilitation professionals in the Mixteca region, he was asked to be the on-site research coordinator. In addition to these qualifications, Mr. Galicia García was of Mixteca decent and was a person with a disability.

Project Advisory Committee. Mr. Galicia García met with key government officials and decision makers, health care educators, community service representatives, and indigenous people with disabilities in order to

develop a Project Advisory Committee (PAC) (see Acknowledgments and Appendix D). In February, 1996, AIRRTC research specialist Mr. George Gotto visited Huajuapan de León along with a project consultant from *Acceso Libre*, Mr. Germán Pérez Cruz. Together, Mr. Gotto, Mr. Galicia García and Mr. Pérez Cruz met with four different agency leaders within the city of Huajuapan de León to discuss the project and ask for official support. The Mayor, Sr. Luis de Guadalupe Ramirez Martinez, of Huajuapan de León was the first to be approached. In addition to the Mayor, his wife, Maria Concepción Sanchez Loyola, *Presidenta, del Desarrollo Integral de la Familia [DIF] Municipal* [President of the Municipal Complete Program for Family Development] was present at this meeting. Both expressed their willingness to be members of the PAC. Additionally, they volunteered the municipal government's support by offering the use of fax and copy machines, as well as any political support that they could give to the project.

The third person who was approached was Dr. Raúl Palma Guzman, Director of the General Hospital of Huajuapan. Dr. Palma Guzman was very enthusiastic about the project. He agreed to be on the PAC and asked to meet with Mr. Galicia García once a month in order to talk about the project. Finally, the group met with Ms. Griselda Galicia García, the director of the *Unidad Regional de Culturas Populares* [Regional Union of Popular Cultures]. Ms. Galicia García was also very interested in the project and agreed to be a member of the PAC.

Interviewer training. During his trip to Huajuapan de León in February, 1996, Mr. Gotto conducted an interviewer training session (see, e.g., Marshall & Johnson, 1990) with seven members of ADM. These seven members had volunteered to travel throughout the Mixteca region to interview indigenous people with disabilities who lived in remote rural

areas. This was a four-hour training session with the purpose of teaching the interviewers how to interview objectively and record responses accurately. Topics that were covered in this training session included confidentiality, the influence of the interviewer on the investigation, and the responsibilities of the interviewer (Interviewer training guide is available upon request from the AIRRTC).

Data Collection

Beginning in February, 1996, the interviewers began surveying people with disabilities in order to identify and assess their life situations. The initial areas targeted for the investigation included the following towns: Huajuapan de León, San Sebastián Progreso del Municipio de Huajolotitlan, and Sta. Maria el Zapote Huajolotitlan. These towns were selected because they had a high number of people with disabilities who were in need of specialized rehabilitation services, as well as a rehabilitation center that could provide vocational training programs for the people with disabilities.

The time frame for collecting data was set between January and March, 1996. Samples were taken from other towns and villages, expanding the area of investigation to include the Santo Domingo Tonalá County, as well as the following communities: Yelta de Juárez, San Isidro el Naranjo, Tezoatlan, Juquila de León, and San Martín del Río Tezoatlan. The area of Huajolotitlan also includes a ranch (Guadalupe de Cárdenas) that was very difficult to reach because of its geographic situation. The survey was concluded in March. A total of 140 questionnaires were collected.

Data collection demanded more time than expected because of the lack of confidence the people had in the research process. They were unaccustomed to research interviews, and the majority of the population expected to be helped by the government without taking into consideration

that before they could get any help, they had to provide a proposal, or documentation of needs.

Data Analysis

During a trip to Oaxaca in February, 1996, Mr. Gotto conducted a three-day training session on the use of the *Statistical Package for the Social Sciences* (SPSS) *for Windows* (SPSS for Windows, 1994) with project consultants Gabriella García Juárez, Germán Pérez Cruz, and Pedro Flores Rey. The purpose of this training session was to teach the project consultants how to create a data base using *SPSS for Windows*, how to enter the data, and how to do basic analysis of this data.

Following the data collection process in the Mixteca, the completed surveys were sent to Gabriela García Juárez in Oaxaca City, who entered the quantitative data into *SPSS for Windows*. Ms. García Juárez then sent the completed surveys and a file of the data base to AIRRTC researchers for further analysis. AIRRTC researchers also completed the qualitative data analyses using *The Ethnograph* (Seidel, Kjolseth, & Seymour, 1988).

RESULTS

General Overview

A total of 140 individuals with disabilities were surveyed in the Mixteca region of Oaxaca, Mexico. All but one of the respondents [99% (139)] reported that their ethnicity was Mixteca (One person did not report his ethnicity). In addition, the majority of the respondents [66% (93)] were from rural towns and villages in the Mixteca region. The remainder of the respondents [34% (47)] were from urban areas such as Huajuapan de León, the Capital of the Mixteca region (see Figure 1).

Figure 1

Urban and Rural Respondents
N = 140

The majority of the respondents were males [66% (92)], with 34% (48) of the respondents being female. For the purpose of analysis, respondents were categorized as *Adults* (15 and older) and *Children* (14 and younger). (The justification for classifying *Adults* as "15 years and older" was that 15 years was the accepted working age in the state of Oaxaca). *Adults* made up 65% (91) of the survey respondents. The remainder of the respondents were 49 *Children* (35%). The mean age among all respondents was 26 years.

Cerebral palsy was the most common disability that was reported among the respondents, followed by mental retardation, polio, and congenital malformations (see Table 1). Table 1 also indicates that there are a large number of respondents who listed their disability as "Other." Some of the disabilities that fell into this category were dislocated hip, curved spinal column, and autism. On average, the respondents reported having their

Table 1

Disability/Pre-condition of Respondents

Disability/Pre-condition	%	#
Cerebral Palsy	21%	29
Mental Retardation	10%	14
Polio	9%	13
Congenital Malformation	7%	10
Paraplegia	5%	6
Developmental Disorder	5%	6
Amputation	4%	5
Vision Impairment	4%	5
Blindness	4%	5
Deaf	3%	4
Epilepsy	3%	4
Spina Bifida	2%	3
Rheumatic Fever	2%	3
Speech Impairment	2%	3
Hyper Activity	2%	3
Muscular Dystrophy	1%	2
Infantile Paralysis	1%	2
Sciatic Nerve	1%	2
Burn	1%	2
Blood Clot	1%	2
Arthritis	1%	2
Other	11%	15

disability for 16 years, with a range between 1 and 55 years. The majority of respondents reported that they had a congenital disability [59% (83)], followed by 21% (29) who reported having a disability due to an accident, and 19% (27)

who had a disability due to illness. Table 2 demonstrates that speech was the area most commonly affected by the respondents' disabilities [37% (52)]. In addition, a relatively large number of disabilities affected the respondents' brains, vision, and/or lower limbs. All of the respondents [100% (140)] reported that they did not have access to resources or service systems where

Table 2

Part of Body Affected by Disability

Affected Area	Percent of Individuals		Percent of Responses*
	%	#	%
Speech	37%	52	27.1%
Brain	29%	40	20.8%
Lower Limbs	22%	31	16.1%
Vision	10%	14	7.3%
Lower Right Limb	9%	12	6.3%
Lower Left Limb	7%	9	4.7%
Upper and Lower Limbs	7%	9	4.7%
Upper Left Limb	5%	7	3.6%
Hearing	5%	7	3.6%
Upper Limbs	4%	5	2.6%
Upper Right Limb	1%	1	.5%
Other	4%	5	2.6%

*Note: N of responses = 192; some of the 140 individuals had more than 1 part of the body affected

they lived that could help them with their disability. When asked which services they needed most, the majority [69% (96)] of the respondents reported that they needed ***physical rehabilitation***, 55% (77) needed ***emotional support***, and 53% (73) needed ***health care***.

Adult vs. Child Comparisons

Adults

As was mentioned earlier, 65% (91) of the survey respondents were adults. A majority of the adult respondents [61% (56)] were from rural areas of the Mixteca region with the remaining 39% (35) of the adults living in an urban setting. The majority of the adults were men [66% (60)], with women making up 34% (31). Well over half of the adult respondents reported being single [59% (54)]. The remainder of the adult respondents were either married [32% (29)], widowed [4% (4)], or had another type of relationship [3% (3)]. One of the adults did not report his marital status. A third of the adults [33% (30)] reported having dependents. The average number of dependents among the adults was four. In contrast, just over two-thirds of the adult respondents [69% (63)] reported that they depended upon another person for living expenses. ***A large majority of the adult respondents [69% (63)] did not receive an income***. The 28 (31%) adults who did receive an income received their wage from employment [24% (22)], pensions [1% (1)], or other sources [5% (5)]. The range of ages among the adults was from 15 years of age to 89 years with the average age being 36 years old. Figure 2 demonstrates that the plurality of adult respondents [42% (38)] had not received an education. In addition, 35% (32) of the school age respondents had only gone to elementary school. Thus, ***77% (70) of the adult respondents had no more than an elementary education***.

Figure 2

Education Level of Adult Respondents
N = 91

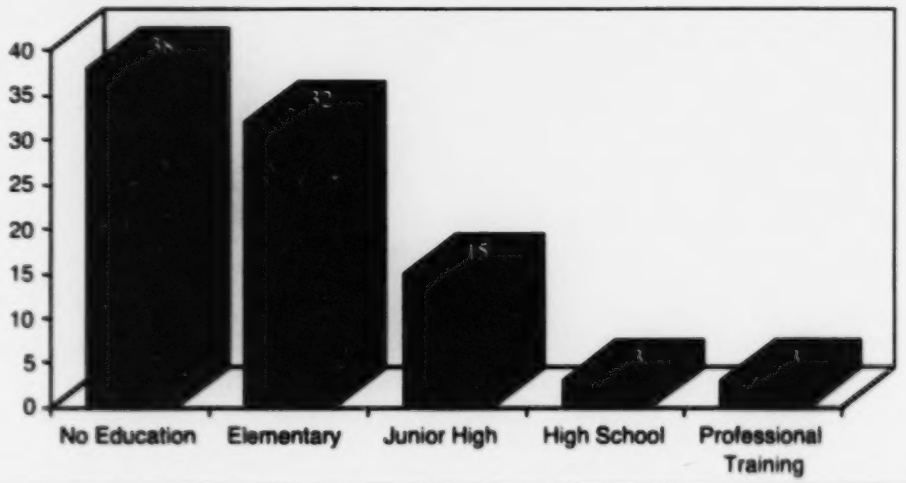


Table 3 indicates that those adults who were unemployed were more likely to have an elementary education or less. On the other hand, those respondents who were employed were equally divided between those with an elementary education or no education and those that had more than an elementary education.

Table 3

Employment and Education Levels of Adult Respondents

Education Level	Unemployed	Employed	Pension	Other
No Education	30	5	0	3
Elementary	25	6	0	1
Junior High	7	6	1	1
High School	1	2	0	0
Professional Training	0	3	0	0

As Table 4 indicates the most common disability among the adults was cerebral palsy, followed by polio and paraplegia. A plurality of the adult respondents reported that their disabilities were congenital [40% (37)]. The remainder of the respondents had a disability due to accidents [30% (27)] and illness [30% (27)]. The adults reported that areas of their bodies that were affected most by their disabilities were the lower limbs [27% (24)], speech [27% (24)], and the brain [22% (20)]. ***In terms of their most urgent needs, the adults reported that they needed physical rehabilitation [67% (61)], employment [61% (56)], health care [50% (46)], emotional support [50% (46)], and education [42% (38)].***

Table 4 Disability/Pre-condition of Adult Respondents		
Disability/Pre-condition	**%**	**#**
Cerebral Palsy	19%	17
Polio	14%	13
Paraplegia	7%	6
Amputation	6%	5
Vision Impairment	6%	5
Blindness	6%	5
Mental Retardation	5%	5
Developmental Problems	4%	4
Congenital Malformation	4%	4
Rheumatic Fever	3%	3
Muscular Dystrophy	2%	2
Speech Impairment	2%	2
Infantile Paralysis	2%	2
Sciatic Nerve	2%	2
Blood Clot	2%	2
Burn	2%	2
Arthritis	2%	2
Deaf	1%	1
Epilepsy	1%	1
Other	9%	8

Qualitative Results

In response to the question, "In your opinion, what are the most urgent needs of people with disabilities," adults referred primarily to ***rehabilitation*** [41% (37)], followed by ***medical attention*** [37% (34)], and

employment opportunities [37% (34)]. In regard to rehabilitation, one man commented, "Rehabilitation that permits me to undertake my own activities despite my disability." Another man commented on both his need for medical attention and employment, "That the medical attention that we, the people with disabilities, receive is fulfilled without so many steps and, in terms of work, that more sources of employment are opened."

The respondents were also asked to comment on how the survey could be improved. The most common responses to this question were requests for ***information***, and that ***the survey be completed and the results disseminated.*** In terms of information, one woman made a fairly common request when she wrote, "That you tell us where we should direct ourselves for our needs." Another person requested, "Direct us to centers for attention in order to continue helping me so I can be self-sufficient." Two of the respondents commented on both completing the survey and disseminating the results. Specifically, one man commented, "I hope this investigation continues and that we can see the results." Similarly, a man with polio commented, "That you complete the objective of this survey, that it doesn't go to a file and stay there because there are many people who need help."

When the respondents were asked if they had any further comments, many of them expanded on their need for information and rehabilitation. In terms of information, one man who was blind said, "When we get sick, we don't know where to go." A woman with cerebral palsy asked, "That you help us to know how to gain the capabilities to overcome [our disabilities]." There were also concerns regarding physical rehabilitation. For example, a man with polio wrote, "Due to lack of rehabilitation, there are several problems with the affected area of the body." Another man with paraplegia

commented, "Due to lack of rehabilitation, there are deformations in the muscles."

Interviewers were also asked to make comments regarding their view of the respondent's situation. When commenting on the situation of the indigenous adults, interviewers primarily discussed ***employment*** and ***education***. However, they also commented extensively on the ***life situation*** of the respondents. Regarding employment, the interviewers usually commented on the ability and desire of a respondent to work. For example, in describing a young man with a developmental disability, one interviewer wrote, "A young man with the ability to learn an occupation and integrate himself through productivity and work." In commenting on a man with paraplegia, another interviewer wrote, "An older man with the ability to work and complement his studies." In terms of education, the interviewers either discussed the lack of education or the desire for an education. For example, one interviewer wrote in regard to a woman with an amputation, "A young woman with an interest in studying, but her parents will not allow it." Another interviewer wrote, "A young man with the ability to continue his studies and/or learn some productive occupation." Finally, the interviewers also commented extensively on the ***life situation*** of the respondents. For example, in describing the situation of a man with cerebral palsy an interviewer wrote, "A young man with cerebral palsy, although the doctor says that he is mentally retarded, but the young man responds correctly to exterior stimulation." The description that another interviewer gave of a man who was deaf was, "An old father who has a daughter with polio, began to lose his hearing and more recently he suffered an infection in his eyes. He has work so that he can take care of himself and his daughter."

Children

As was mentioned earlier, children made up 35% (49) of the total research sample. The average age of the children was 9 years old. The majority of the children, or their parents, who responded to the survey were boys [65% (32)]. Girls represented 35% (17) of the children who responded to the survey. Three-quarters [75% (37)] of the children lived in rural areas of the Mixteca region; the remaining quarter [25% (12)] lived in urban areas. ***There were a total of 37 children who were old enough to go to school (between 6 and 14 years old). The majority of these 37 children [59% (22)] reported that they had no education***. As with the adults, the most common disability that was reported by the children was cerebral palsy [25% (12)]. Other disabilities that were reported at a relatively high frequency included congenital malformations [12% (6)] and mental retardation [12% (6)]. The average length of time that the children reported having their disabilities was eight years. The vast majority of the children [94% (46)] reported that their disabilities were congenital; 4% (2) of the childrens' disabilities were caused by accidents, and one child (2%) did not report the cause of his disability. Areas of functioning that were most often affected by the childrens' disabilities were speech [57% (28)] and the brain [41% (27)]. ***Physical rehabilitation was the greatest need that the children reported [73% (35)]. Other needs that the children reported were emotional support [64% (31)], health care [56% (27)], education [56% (27)], and employment [8% (4)]***.

Qualitative Results

The children or their parents were also asked the question, "In your opinion, what are the most urgent needs of people with disabilities." The three most commonly mentioned needs were ***medical attention*** [43% (21)], ***specialized attention*** [35% (17)], and ***rehabilitation*** [33% (16)]. Most of the

children or parents that commented on medical issues did not elaborate on their medical needs; they simply said, "medical attention." In terms of specialized attention, the children or their parents said they needed "specialized attention," "specialized medical attention," or "specialized rehabilitation." In some cases the parents made more extensive comments such as, "Specialized clinic that has the necessary service in order to receive specialized attention according to the disability of each person." In terms of rehabilitation, the parents made comments such as, "Rehabilitation and health for the children with this problem."

When asked, none of the children or adults made comments on how the survey could be improved. However, some of them did ask for information. For example, one parent said that he would like, "information and help to channel them to institutions that correspond to their need." Another parent requested, "that they give talks so that we may understand what disabilities are and why there is so much difference between them."

Expanding on the needs of the indigenous children, comments were made such as the following regarding a boy who was mentally retarded: "Help us to learn where there are the resources to develop his intelligence." In regard to a girl with an unknown congenital disability, the parents commented that "due to lack of economic resources, she had not received medical attention." The parent of a second child with an unidentified disability wrote, "We have never been told what the name of his illness is." Similarly, an interviewer gave the following comment regarding the family of a boy with epilepsy, "We need to have more information about his disability so that we can orient the family and tell them how to proceed."

Interviewers had many comments regarding the needs of the indigenous children. For example, one interviewer wrote this about a girl

who had cerebral palsy: "Due to lack of information and ignorance, the family has lost a lot of time for the little girl who has never received medical attention." Another interviewer made the following comment about a boy with cerebral palsy, "If he had the opportunity to attend a school or special education center, he could integrate himself through productive work." Regarding another boy with cerebral palsy, one interviewer commented, "Young boy with great abilities to learn an occupation and to be independent in many aspects."

Urban vs. Rural Comparisons

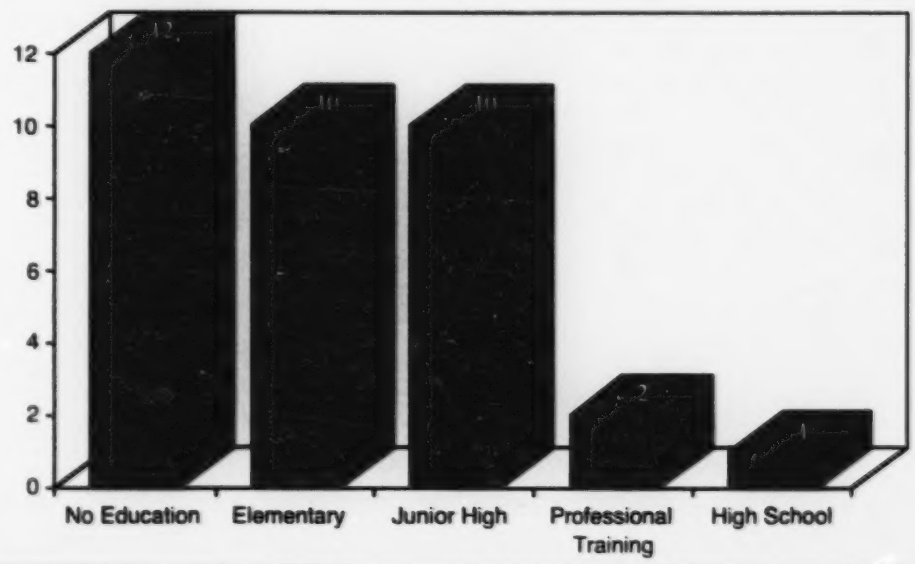
Urban

As was mentioned earlier, a little over a third of the respondents [34% (47)] were from urban areas. Nearly three-quarters of the urban residents with disabilities were male [72% (34)]; whereas females made up 28% (13) of the urban respondents. The average age of the urban respondents was 30 years old. Adults made up three-quarters of the urban respondents [75% (35)]. Among the urban adults, nearly half were married [49% (17)], 46% (16) were single, and 5% (2) reported having another type of relationship.

As Figure 3 indicates, approximately a third of urban adults [34% (12)] did not have an education. In addition, Figure 3 demonstrates that very few of the urban adults had either a high school [3% (1)] or professional [6% (2)] education. In terms of employment, the majority of the urban adults

Figure 3

Education Level of Urban Adults
N = 35



[57% (20)] did not have a job. Those urban adults who did receive an income, obtained it through employment [31% (11)], pension [3% (1)], or other means [9% (3)]. A little over half of the urban adults [51% (18)] reported that they had an average of two dependents.

Polio was the most commonly reported disability among all respondents [15% (7)] from urban areas. Two of the other most common disabilities that were reported were cerebral palsy [11% (5)] and developmental problems [9% (4)]. On average, the urban respondents reported having their disability for 15 years. A plurality of the urban respondents reported that their disability was congenital [42% (20)]; 30% (14) said their disabilities were due to illness, and 28% (13) said that accidents were the cause of their disabilities. The areas of the body that were most affected by the disabilities among the

urban respondents were the lower limbs [26% (12)], brain [26% (12)], and speech [26% (12)]. All of the urban respondents reported that there were no disability services available to them. However, as Table 5 indicates, the urban respondents reported most needing ***physical rehabilitation, emotional support,*** and ***health care.***

Table 5

Rehabilitation Needs of Urban Respondents

Area of Need	Percent of Individuals		Percent of Responses*
	%	#	%
Physical Rehabilitation	70%	33	27.3%
Emotional Support	62%	29	24.0%
Health Care	47%	22	18.2%
Employment	40%	19	15.7%
Education	36%	17	14.0%
Other	2%	1	.8%

*Note: N of responses = 121; some of the 47 individuals had more than 1 rehabilitation need

Qualitative Results

In response to the question, "In your opinion, what are the most urgent needs of people with disabilities," the urban respondents commented on ***rehabilitation*** [45% (21)], ***employment*** [36% (17)], and ***medical issues*** [32% (15)]. In terms of rehabilitation, the urban respondents made comments such as, "Centers for specialized attention. Areas that offer work or teach

some occupation," and "Specialized attention in order to receive new rehabilitation therapies." Regarding employment, the urban respondents made very basic comments. For example, a man who was disabled due to severe burns commented, "Sources of work for people with disabilities." In another instance, a man who had had polio said, "come up with more sources of employment." Although many of the urban respondents commented that they needed medical attention, they did not make any extended comments. In general, they either needed "medical attention" or "specialized medical attention."

The urban respondents did not have any suggestions regarding how the survey could be improved. However, ***they did ask that the survey be completed, that the survey results be disseminated, and that they be given more information regarding their disabilities***. A man who had an amputation made the following comment regarding both the completion of the survey and dissemination of the results, "That you carry out this survey and also that you let the people or institutions that can support us know and if possible the government of the Federal District." In terms of needing more information, the urban respondents either wanted to understand more about their disabilities or they wanted to know where they could get help. The parents of an urban child with epilepsy said, "Inform the parents of the family what measures they should take in accordance with the disability and how they can help." An urban man with infantile paralysis asked the following question regarding the need for information, "Which are the institutions that can give us support with our requests?"

Expanding on the needs of the urban respondents, receiving physical rehabilitation was a concern for them. For example, the parents of an urban child with a developmental disability said, "We don't know what type of

rehabilitation he needs." Regarding another urban child who had cerebral palsy, the parents wrote, "Due to lack of rehabilitation, he is losing mobility." Finally, an urban man said that he needed "rehabilitation that will allow him to exercise the muscles that were affected."

The two main concerns that the interviewers had for the urban respondents had to do with education and work. In terms of education, the interviewers made comments such as: "Young man with the capability to further his studies, learn an occupation, or fill an administrative post," and "Young woman with the capability to continue with her studies since she already has great desires to overcome." Regarding work, the interviewers generally made comments that had to do with a persons ability to work. For example, regarding a man with cerebral palsy, an interviewer said, "If he had the opportunity to learn an occupation he could do it since he already had the capability to work." In reference to a man with polio, one interviewer wrote, "A young man with the ability to learn some occupation and generate more income."

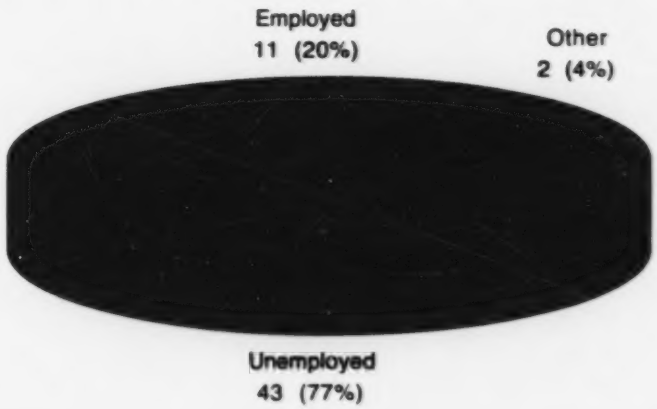
Rural

Approximately two-thirds of the survey respondents [66% (93)] were from rural areas. There were more male respondents [62% (58)] than female respondents [38% (35)] in the rural areas of the Mixteca. The range of ages among the rural respondents was from less than a year old to 89 years of age. The average age was 24 years old. The majority of the rural sample were adults [60% (56)], with children comprising 40% (37) of the rural sample. Among the rural adults, 68% (38) reported being single, 21% (12) were married, 7% (4) were widowed, 2% (1) reported "other" for type of relationship, and 2% (1) did not report marital status.

The vast majority of the rural adults [86% (48)] either had no education or no more than an elementary education. The remaining rural adult respondents either had a junior high school [9% (5)], high school [4% (2)], or professional level [2% (1)] education. As Figure 4 indicates, only 20% (11) of the rural adults were employed. The majority of the rural adults [79% (44)] did not have dependents. Among the 12 (21%) rural adults who did have dependents, the average number of dependents was 3 persons. Over three quarters of the rural adults [77% (43)] reported that they received their living expenses from another person.

Figure 4

Employment Status of Rural Adults
N = 56



The most common disability among all rural respondents was cerebral palsy [26% (24)]. Congenital malformations [10% (9)], polio [7% (6)], and mental retardation [5% (5)] were other disabilities reported with the highest frequency. As a result of these disabilities, the areas of functional limitation

most commonly reported affected speech [43% (40)], the brain [30% (28)], and lower limbs [20% (19)]. On average, the rural respondents reported that they had had their disabilities for 16 years. The causes of the disabilities were illness [14% (13)], accidents [17% (16)], and congenital [68% (63)] (one person [1%] did not report the cause of his disability). None of the rural respondents reported that they had access to services for people with disabilities; yet reported a variety of needs (see Table 6).

Table 6

Rehabilitation Needs of Rural Respondents

Area of Need	Percent of Individuals		Percent of Responses*
	%	#	%
Physical Rehabilitation	68%	63	25.1%
Health Care	55%	51	20.3%
Education	52%	48	19.1%
Emotional Support	52%	48	19.1%
Employment	44%	41	16.3%

*Note: N of responses = 251; some of the 93 individuals had more than 1 rehabilitation need

Qualitative Results

In response to the question, "In your opinion, what are the most urgent needs of people with disabilities," the indigenous rural respondents overwhelmingly commented on ***medical issues*** [49% (46)] and ***rehabilitation*** [34% (32)]. Most of the indigenous rural respondents did not elaborate on

their medical needs other than to say that they needed "medical attention" or "specialized medical attention." However, one man with vision problems commented, "That the medical attention that we, the people with disabilities, receive is fulfilled without so many steps. . . ." Another man who had problems with his hip said that he would like a little more than medical attention, "Medical attention and improvement in my nourishment." The parents of a child who had cerebral palsy expressed their need for much more than medical assistance: "Improve nourishment and receive help with specialized medical attention and rehabilitation." In regard to rehabilitation, one man with cerebral palsy commented that there was a need "to make the people with cerebral palsy productive people through vocational training."

Although there were not very many responses to the question, "Do you have a question or would you like to give us a suggestion about how to improve this survey," there were a few rural respondents who suggested that they would like to have health care and rehabilitation services offered closer to their home. For example, a man with cerebral palsy said, "Put a specialized medical unit in our community." The parents of a child with cerebral palsy asked, "Can you implement programs of attention in the village?" Finally, a man who was blind requested, "that you encourage the authorities to put a rehabilitation center near the community."

Expanding on the needs of the rural respondents, comments were made regarding information. For example, the parents of a boy with cerebral palsy wanted to know "how to help him with his disability." One interviewer made the following comment regarding a young man who did not know the name of his disability: "A young man who does not know the specific cause of his disability; well, he fell from a height of 50 centimeters

(20 inches) onto a table of nails, two of which punctured him and days afterwards he lost movement in his left limbs."

The interviewer comments demonstrated that their greatest concerns for the indigenous rural respondents had to do with employment and education. In terms of employment, one interviewer said this about a man who had paraplegia, "An older man with the capability to work and finish his studies." Regarding a child with cerebral palsy, another interviewer wrote, "Despite his disability, he is accomplishing his work in the fields." Finally, another interviewer made this comment regarding a woman with muscular dystrophy: "A young woman who lives in a rural area that is very far and difficult to access. She could not work permanently due to lack of opportunities. She believes that she could work out of her own home." Even though the respondents did not comment on education, the interviewers made several comments on the respondents' ability to complete an education or the need for education. For example, in reference to a young woman with polio, one interviewer said, "A young woman who has a great desire to study and learn an occupation or to finish her education." Regarding a man who had speech problems, one interviewer wrote, "Young man could study if he had the necessary support; he could learn how to study despite his speech problem." Finally, an interviewer wrote the following about a rural woman who had cerebral palsy: "Has the capability to learn to read and write. She has great desires to learn; she could learn an occupation."

Indigenous Women with Disabilities

As reported earlier, 34% (48) of the 140 research participants were female; of these females, just over a third [35% (17)] were female children with disabilities. The remaining females [65% (31)], ages 15 and older, were

considered *Adults* for the purpose of data analyses. Thus, adult women with disabilities made up 22% of the study population.

Rural Indigenous Women with Disabilities

Of the 31 adult indigenous women with disabilities, a large majority [74% (23)] lived in rural areas of the Mixteca region, and were originally from the areas of San Sebastián, Tonalá, Tezoatlan de Segura y Luna, Yetla, San Isidro el Naranjo, Llano Grande, y Santiago Huajolotitlan. All of the women were Mixteca.

They reported an average age of 32 years, with a wide range in age from 15 to 70. However, only two of the women might be considered "adolescents," with ages 15 and 16. A large majority [70% (16)] of the women were single; 13% (3) were married and 13% (3) were widowed. The majority [83% (19)] of women reported that they were dependent upon someone for their socioeconomic well-being. Just over a quarter [26% (6)] of the women were responsible for, on average, one dependent, with a range of between one to four dependents.

Disability Status

The plurality, or most of the rural women reported their disability as cerebral palsy, followed by polio and vision impairment (see Table 7). On average, the women reported having had their disability for 21 years, with a range between 4 and 42 years. The majority [52% (12)] reported having a congenital disability, followed by just under a third [30% (7)] having a disability due to an illness, and the remainder [17% (4)] having a disability due to an accident. Parts of the body resulting in functional limitations are presented in Table 8.

Table 7 Disability/Pre-condition of Rural Indigenous Women		
Disability/Pre-condition	**%**	**#**
Cerebral Palsy	35%	8
Polio	13%	3
Vision Impairment	13%	3
Amputation	9%	2
Muscular Dystrophy	9%	2
Rheumatic Fever	9%	2
Blindness	4%	1
Epilepsy	4%	1
Mental Retardation	4%	1

Table 8

Part of Body Affected by Disability for Rural Indigenous Women

Affected Area	Percent of Individuals		Percent of Responses*
	%	#	%
Lower Limbs	26%	6	21.4%
Speech	26%	6	21.4%
Brain	22%	5	17.9%
Lower Right Limb	13%	3	10.7%
Vision	13%	3	10.7%
Lower Left Limb	9%	2	7.1%
Upper Left Limb	4%	1	3.6%
Upper Right Limb	4%	1	3.6%
Other	4%	1	3.6%

*Note: N of responses = 28; some of the 23 individuals had more than 1 part of the body affected

Education and Employment

All of the women with the exception of one [96% (22)], ***had only an elementary school education or less*** (see Table 9). This one woman had gone on beyond elementary school to complete high school. Almost half of the women had no education.

Table 9

Education Level of Rural Indigenous Women with Disabilities

Education Level	%	#
No Education	48%	11
Elementary	48%	11
High School	4%	1

The vast majority [87% (20)] of the women did not have an income; those who did have an income [13% (3)] were employed. Positions included housekeeping (2) and temporary/odd jobs (1). The woman with the highest level of education was not employed (see Table 10).

Table 10

Employment and Education Levels of Rural Indigenous Women with Disabilities

Education Level	Unemployed	Employed
No Education	10	1
Elementary	9	2
High School	1	0

Rehabilitation Needs

All respondents reported that there were ***no resources or service systems*** where they lived to help them with their disability. Specific needs are listed below in Table 11 .

Table 11

Rehabilitation Needs of Rural Indigenous Women

Area of Need	Percent of Individuals		Percent of Responses*
	%	#	%
Physical Rehabilitation	74%	17	27.0%
Employment	65%	15	23.8%
Health Care	48%	11	17.5%
Education	44%	10	15.9%
Emotional Support	44%	10	15.9%

*Note: N of responses = 63; some of the 23 individuals had more than 1 rehabilitation need

Qualitative Results

In response to the question, "In your opinion, what are the most urgent needs of people with disabilities," the rural indigenous women referred primarily to ***medical attention*** [39% (9)], followed by ***education and vocational training*** [22% (5)], and ***employment opportunities*** [17% (4)]. In regard to employment opportunities, one woman commented, for example, that people with disabilities needed to be able "to count on real support in sources of employment since we have been forgotten by society."

Research participants were asked to comment on how the survey could be improved; rather than comment on the survey instrument, the women gave suggestions/comments which indicated that ***they were very interested in receiving concrete assistance***. For example, one women commented, "Tell us where we should direct ourselves for our needs." A women with vision impairment requested "that they develop courses that are open to people with disabilities." A second women with vision impairment commented, "Put in a center of specialized attention for us." One women with an amputation, who identified education and vocational training as primary needs of people with disabilities, asked, "Can you assist me in my community or give me a grant?" One women with cerebral palsy commented that she would like "to be able to count on a center of special education;" two other women with cerebral palsy stated that centers for physical rehabilitation were necessary.

Expanding on the ***needs/capabilities of the individual women,*** comments were made such as this in regard to a women who had had polio: "She needs an orthopedic apparatus. Her current apparatus is not comfortable because of the material with which it was made." In regard to a woman with an amputation, an interviewer commented: "This young woman has a desire to study but her parents won't allow it." In referring to the capabilities of a women with cerebral palsy, an interviewer commented, "Help us to understand where she can excel." Similarly, another woman with cerebral palsy commented, "I would like to be permitted to know how far I can go forward."

Interviewers had many ***positive comments in regard to the womens' potential capabilities***: In regard to women with cerebral palsy, comments included: "A young woman who has a great desire to study and learn an

occupation or finish her education," and "A young woman who needs work. She has a great desire to integrate herself productively." In regard to a woman with vision impairment: "A young woman who has the capacity to do artisan activities within the group of people with disabilities, which fills her with satisfaction and drives her to have greater ambitions." In regard to a woman with cerebral palsy: "Adolescent who could develop some level of learning in a specialized center." In regard to three additional women with cerebral palsy: (1) "Has the capability to learn to read and write and has great ambition to do it so that she can learn an occupation," (2) "A young woman with the capability to learn an occupation," and (3) "A young woman with the capability to learn an occupation. Her mental retardation is hardly noticeable. I think that with a little help in rehabilitation, she could be completely independent." Finally, in regard to a woman with delayed mental development, an interviewer commented, "The woman, in spite of her mental condition, seems very lucid and possibly, with occupational therapy, she could be integrated into society through her productivity."

The following comments were indicative of the ***problems caused by isolation and a non-accessible environment*** rather than the disability: "A young woman that lives in a rural area that is far away and difficult to access. She can't work permanently because there aren't any opportunities. She believes that she could work in her own home." In describing the situation of a women with cerebral palsy, an interviewer stated, "This person, because of where she lives, is isolated and practically confined." In regard to a women who had had polio: "An older woman, who because of her situation, didn't finish her studies nor did she leave her community. She has lived taking care of her father. At this time, she has a small store, but she would like to learn another type of work in order to better her economic situation."

Interviewers also noted ***problems of family dependency and lack of appropriate intervention***. For example, regarding a young woman with vision impairment, an interviewer observed: "The youngster is totally dependent on her parents, the loss of her vision is irreversible and getting worse." Similarly, an interviewer commented in regard to a woman with an amputation, "A young woman who, because she is part of a family that belongs to a religion that doesn't respect patriotic symbols, was pulled out of school and has not returned to studying." The lack of appropriate intervention for several rural women was highlighted in comments such as, "For 25 years, due to a fall and lack of medical attention, she lost her right arm," and "A young woman who cannot move, mostly because she didn't get attention."

Urban Indigenous Women with Disabilities

Of the 31 women with disabilities, just over a quarter [26% (8)] lived in urban areas of the Mixteca region, and were originally from areas such as Huajuapan de León and Acatlima. All of the women were Mixteca. The average age of the 8 women was 29; they ranged in age between 20 and 35. The majority [75% (6)] of the women were single; one woman was married. Similarly, the majority [75% (6)] of the women reported that they depended on someone for their socioeconomic well-being. Just over a third [37% (3)] of the women reported having dependents; two women reported having two dependents each and one woman reported having eight dependents.

Disability Status

The eight women reported having eight different disabilities (or conditions which resulted in disability), specifically: polio, amputation, vision problems, delayed development, congenital malformation, cerebral

palsy, down syndrome, and infantile paralysis. Parts of the body resulting in functional limitations are presented in Table 12.

The women reported having had a disability for an average of 22 years, with the majority [63% (5)] having a congenital disability, followed by a quarter [25% (2)] having had an accident, and 12% (1) having a disability as the result of an illness.

Table 12

Part of Body Affected by Disability for Urban Indigenous Women

Affected Area	Percent of Individuals		Percent of Responses*
	%	#	%
Brain	50%	4	30.8%
Lower Left Limb	25%	2	15.4%
Speech	25%	2	15.4%
Lower Limbs	12%	1	7.7%
Upper Left Limb	12%	1	7.7%
Upper and Lower Limbs	12%	1	7.7%
Vision	12%	1	7.7%
Other	12%	1	7.7%

*Note: N of responses = 13; some of the 8 individuals had more than 1 part of the body affected

Education and Employment

The women reported having extremely limited education (see Table 13). The one women with professional training reported being a nurse.

Table 13

Education Level of Urban Indigenous Women with Disabilities

Education Level	%	#
No Education	25%	2
Elementary	25%	2
Junior High	38%	3
Professional Training	12%	1

The majority of urban women [63% (5)] reported that they did not receive an income. Those that did receive an income [38% (3)] were employed. Positions included housekeeping, hostess, and head of nursing. Two of the three employed women were among the highest educated (see Table 14), although the range of education between the two women varied greatly--junior high school versus professional training as a nurse.

Table 14

Employment and Education Levels of Urban Indigenous Women with Disabilities

Education Level	Unemployed	Employed
No Education	1	1
Elementary	2	0
Junior High	2	1
Professional Training	0	1

Rehabilitation Needs

All respondents reported that there were ***no resources or service systems*** where they lived to help them with their disability. Specific needs of urban women are listed below in Table 15.

Qualitative Results

In response to the question, "In your opinion, what are the most urgent needs of people with disabilities," the eight urban women expressed a variety of needs. Four women indicated that employment was needed such as, "help for employment and medical attention;" "employment that permits you to pay your bills;" "work that augments my wages;" and "vocational training and employment." Additionally, the women indicated as needs, "communication and rehabilitation (physical);" "more information for people regarding their problems or centers of rehabilitation in this city;" and,

Table 15

Rehabilitation Needs of Urban Indigenous Women

Area of Need	Percent of Individuals		Percent of Responses*
	%	#	%
Employment	63%	5	25%
Emotional Support	50%	4	20%
Education	50%	4	20%
Physical Rehabilitation	50%	4	20%
Health Care	38%	3	15%

*Note: N of responses = 20; some of the 8 individuals had more than 1 rehabilitation need

simply, a "rehabilitation center." One woman was concerned with emotional support and stated, "Psychological help [is needed] so that we can accept how we are as amputees. Already we have had many traumas because of the fact that we lost a limb."

Comments regarding improving the survey focused on follow-through by the researchers in terms of actually ***providing support and intervention***. In the words of one woman, "I hope there will be a rehabilitation center that can help us." The specific intervention needs of one woman were expressed as: "I feel like I am capable of working but I would like to be tested in order to know what I can do."

Additional comments regarding the needs of urban women included, in regard to a woman with Downs Syndrome, "Due to lack of information,

she doesn't move." In regard to a women with vision impairment: "[She needs] help to continue as a student." In the words of a women with an amputation, "If we overcome our traumas, it would be easier to integrate ourselves into society."

As with the rural women, interviewers made comments highlighting the positive aspects of the urban women's lives, as well as comments which identified problem situations. In terms of positive assessments, ***an interest in education*** was mentioned. For example, an interviewer noted in regard to a woman with vision impairment, "A young woman with the capacity to continue studying, since she has a great desire to overcome [her situation]," and in regard to a 28 year old woman who had had polio at age 3, "A young woman who has the capacity to continue studying and complete elementary school."

Problem situations included a ***lack of intervention*** as well as ***overprotection by family***. Specifically, in regard to the woman with Down's Syndrome referred to above, an interviewer commented, "Needs rehabilitation and specialized psychological attention in order to integrate and to accomplish an activity appropriate to her disability." In regard to the woman with an amputation, an interviewer commented, "A young woman with many problems due to the loss of her limb and the overprotection of her family."

Indigenous Men with Disabilities

As reported earlier, 66% (92) of the 140 research participants were male; of these males, just over a third [35% (32)] were male children with disabilities. The remaining males [65% (60)], ages 15 and older, were

considered *Adults* for the purpose of data analyses. Thus, adult men with disabilities made up 43% of the study population.

Rural Indigenous Men with Disabilities

Of the 60 adult indigenous men with disabilities, the majority [55% (33)] lived in rural areas of the Mixteca region, and were originally from the areas of San Sebastián, Tonalá, Tezoatlan de Segura y Laguna, Yetla, El Naranjal, Llano Grande, and Santiago Huajolotitlan. All of the men were Mixteca. They reported an average of 36 years of age, with a wide range in age from 15 to 89. Seven of the men might be considered "adolescents," with ages that range from 15 to 18. A large majority [67% (22)] of the men were single; 27% (9) were married and 3% (1) were widowed. The majority [73% (24)] of men reported that they were dependent upon someone for their living expenses. A small percentage [18% (6)] of the men were responsible for, on average, 3 dependents, with a range of between 1 to 5 dependents.

Cerebral palsy was the most common disability reported by the rural men, followed by polio, congenital malformations, and paraplegia (see Table 16). On average, the men reported having had their disability for 21 years, with a range between 1 and 55 years. The majority [52% (17)] reported having a congenital disability, followed by just under a third [30% (10)] having a disability due to an accident, and the remainder [18% (6)] having a disability due to illness. Parts of the body resulting in functional limitations are presented in Table 17.

Table 16 Disability/Pre-condition of Rural Indigenous Men		
Disability/Pre-condition	**%**	**#**
Cerebral Palsy	18%	6
Polio	9%	3
Congenital Malformations	9%	3
Paraplegia	9%	3
Developmental Disorders	6%	2
Blindness	6%	2
Mental Retardation	9%	3
Speech Impairment	6%	2
Poor Vision	3%	1
Deaf	3%	1
Sciatic Nerve	3%	1
Blood Clot	3%	1
Other	15%	5

Table 17

Part of Body Affected by Disability for Rural Indigenous Men

Affected Area	Percent of Individuals		Percent of Responses*
	%	#	%
Speech	36%	12	27.9%
Brain	27%	9	20.9%
Lower Limb	21%	7	16.3%
Vision	12%	4	9.3%
Lower Right Limb	9%	3	7.0%
Upper Left Limb	9%	3	7.0%
Lower Left Limb	6%	2	4.7%
Upper Limbs	3%	1	2.3%
Hearing	3%	1	2.3%
Upper and Lower Limbs	3%	1	2.3%

*Note: N of responses = 43; some of the 33 individuals had more than 1 part of the body affected

The majority of the rural men [79% (26)], ***had completed only an elementary school education or less*** (see Table 18). Only 6% (2) of the rural men had a high school education or more and nearly half had no education.

Table 18 Education Level of Rural Indigenous Men with Disabilities		
Education Level	**%**	**#**
No Education	46%	15
Elementary	33%	11
Junior High	15%	5
High School	3%	1
Professional Training	3%	1

The majority [70% (23)] of the men did not have an income; those who did have an income [30% (10)] were employed or reported another source of income. All respondents reported that there were ***no resources or service systems*** where they lived to help them with their disability. The specific needs of the rural men are listed below in Table 19.

Qualitative Results

In response to the question, "In your opinion, what are the most urgent needs of people with disabilities," the indigenous rural males indicated that they needed both ***medical attention*** [82% (27)] and ***rehabilitation*** [79% (26)]. One rural man who had cerebral palsy expressed his concern for appropriate medical attention: "That the medical attention that you solicit will come rapidly and without so much bureaucratic steps." Another man expressed his desire to have "medical attention in places that are closer to our town." In terms of rehabilitation, a rural man with cerebral palsy said that he would like, "rehabilitation that permits me to realize my

Table 19

Rehabilitation Needs of Rural Indigenous Men

Area of Need	Percent of Individuals		Percent of Responses*
	%	#	%
Employment	67%	22	22.7%
Health Care	67%	22	22.7%
Physical Rehabilitation	67%	22	22.7%
Education	48%	16	16.5%
Emotional Support	45%	15	15.5%

*Note: N of responses = 97; some of the 33 individuals had more than 1 rehabilitation need

own activities despite my disability." Another man commented, "That you can help people like me, or [provide] centers where they give good rehabilitation and training."

Another area of need that the rural indigenous men and the interviewers identified had to do with ***information***. For example, in referring to a young man with a congenital disease, one interviewer wrote, "A restless young man with many doubts about disabilities who desires to receive information about them." One respondent requested, "That you give talks so that we can understand more about disabilities." Finally, a man who was mentally retarded requested that the interviewer "direct [him] to centers for attention in order to continue helping [him] so [he] can be self sufficient."

Employment and ***education*** were the topics that the interviewers commented on most frequently in relation to the rural males. In terms of employment, the interviewers made comments regarding the respondent's ability to work. For example, in describing a young man with cerebral palsy, one interviewer wrote, "A young man with the aptitude to develop some activity that would allow him to be productive and value himself. He knows how to weave palm leaves and make hats." In another instance, regarding a young man who had had polio, the interviewer commented, "A young man with the capability to learn something related to the occupation that he likes (electronics), which would integrate him into productive labor with greater satisfaction and that would complement his studies." As the comments above indicate, the interviewers felt that education was essential to the rural men getting employment. Other comments that the interviewers made regarding employment were: "A young man with the ability to learn to read and write in order to conclude his studies and he could study a career," and "Has the ability to begin his studies that permit him to advance himself like regular person."

Urban Indigenous Men with Disabilities

Of the 60 men with disabilities, 45% (27) lived in urban areas of the Mixteca region such as Huajuapan de León. All of the men except one reported that they were Mixteca (One man did not report his ethnicity). The average age of the 27 men was 41; they ranged in age between 15 and 80. Two of these men could be considered adolescents as they were both 15 years old. The majority [59% (16)] of the men were married; 37% (10) were single and 4% (1) reported "other" for his relationship. A little over half [52% (14)] of the men reported that they depended on someone for their socioeconomic well-

being. Yet curiously, 56% (15) of the men reported having dependents. The average number of dependents that these 15 men had was 3 people.

The 27 men reported having thirteen different disabilities (or conditions which resulted in disability), such as polio, amputation, vision problems, delayed development, congenital malformation, cerebral palsy, mental retardation, and infantile paralysis. The most common disabilities among these men were polio [22% (6)], paraplegia [11% (3)], and arthritis [7% (2)]. Parts of the body resulting in functional limitations are presented in Table 20.

The men reported having had a disability for an average of 16 years, with almost half [48% (13)] having a congenital disability, followed by 41% (11) having had an accident, and 11% (3) having a disability as the result of an illness.

Table 20

Part of Body Affected by Disability for Urban Indigenous Men

Affected Area	Percent of Individuals		Percent of Responses*
	%	#	%
Lower Limbs	39%	10	29.4%
Lower Right Limb	19%	5	14.7%
Speech	15%	4	11.8%
Visions	11%	3	8.8%
Upper Left Limb	8%	2	5.9%
Upper and Lower Limbs	8%	2	5.9%
Lower Left Limb	8%	2	5.9%
Upper Limbs	8%	2	5.9%
Brain	8%	2	5.9%
Other	8%	2	5.9%

*Note: N of responses = 34; some of the 27 individuals had more than 1 part of the body affected

The men reported having limited education (see Table 21). The one man with professional training reported being an accountant.

Table 21 Education Level of Urban Indigenous Men with Disabilities		
Education Level	**%**	**#**
No Education	37%	10
Elementary	30%	8
Junior High	26%	7
High School	4%	1
Professional Training	4%	1

The majority of urban men [56% (15)] reported that they did not receive an income. Those that did receive an income [44% (12)] were employed, received a pension, or had another source of income. Table 22 indicates that the less education the indigenous urban men had the more likely they were to be unemployed.

All respondents reported that there were ***no resources or service systems*** where they lived to help them with their disability. The urban men reported that they needed ***physical rehabilitation [68% (18)], emotional support [63% (17)], employment [52% (14)], health care [37% (10)], and education [30% (8)].***

Table 22

Employment and Education Levels of Urban Indigenous Men

Education Level	Unemployed	Employed	Pension	Other
No Education	8	0	0	2
Elementary	5	3	0	0
Junior High	1	3	1	1
High School	0	1	0	0
Professional Training	0	1	0	0

Qualitative Results

In response to the question, "In your opinion, what are the most urgent needs of people with disabilities," the urban males indicated that they needed both ***employment*** [48% (13)] and ***rehabilitation*** [48% (13)]. In terms of employment needs, the urban men made comments such as, "Sources of work for people with disabilities," and "Sources of work in order to generate an income." The calls for rehabilitation programs were just as direct. For example, the family members of a man with cerebral palsy said, "Rehabilitation that permits him to get out of his wheelchair." The parents of a boy who was mentally retarded said that their son needed, "Specialized attention in order to receive new rehabilitation therapies."

The comments that were given by the interviewers regarding the needs of the indigenous urban males focused primarily on ***employment*** and ***education***. Regarding education, the interviewers made comments such as:

"A boy who has the ability to continue studying, as he has a hearing aid that helps him to hear and understand what is happening around him," and "Young man with the ability to continue his studies with a desire to excel, and overall has the resources to help others with disabilities." In terms of employment, the interviewers either described the employability of a person or they described a person's employment situation. For example, regarding a man who had a developmental disability, one interviewer wrote, "In employment, although he has his own business, he would like to have access to work in order to better his economic situation." In describing a man who had had polio, another interviewer wrote, "Young man with the capability to learn another occupation and generate more income."

DISCUSSION

A total of 140 indigenous people with disabilities from the Mixteca region of Oaxaca were surveyed. Approximately two-thirds of those who were surveyed were from rural towns and villages such as Santo Domingo Tonalá, Yetla de Juárez, San Isidro el Naranjo, Tezoatlan, Juquila de León, and San Martín del Río Tezoatlan. The remaining one-third of the survey respondents were from the city of Huajuapan de León. In terms of gender, two-thirds of the survey respondents were male and one-third were female. The majority of the survey respondents were adults. The data indicate that among all respondents, cerebral palsy, mental retardation, polio, and congenital malformations were the most commonly reported disabilities. Finally, and perhaps most important, both the quantitative and qualitative results demonstrate that among the 140 indigenous participants with disabilities there was a great need for health care, physical rehabilitation, and

employment; all of which could be met by ***comprehensive rehabilitation programming***.

The results regarding the needs of the survey respondents are particularly disconcerting in light of the fact that 100% of the respondents reported that they had ***no access to resources or service systems where they lived that could help them with their disability***. While, particularly for the urban respondents, there is a hospital (Hospital General Huajuapan) and a grassroots, non-profit organization for people with disabilities (Asociación de Discapacitados de la Mixteca) in Huajuapan de León, apparently neither of these organizations are able to provide those services which indigenous people with disabilities feel they need.

Perhaps one of the most disturbing results from this study is the ***lack of health care*** among the survey respondents. This is particularly true when one considers that three of the most commonly reported disabilities were cerebral palsy, polio, and congenital malformations; each of which can be avoided or ameliorated with proper pre-natal care, early medical intervention, and/or vaccination. The qualitative results in particular reveal that the respondents were in great need of basic medical attention. Consider, for example, the case of the parents who reported that they had never even been told the name of their child's disability. It is highly unlikely that this child will be able to attain his full potential if he is not even receiving the most basic medical attention. Although the quantitative results demonstrate that both the rural and urban respondents were in need of health care, the commentaries of rural respondents strongly indicated that health care was lacking. In particular, rural respondents stated that they needed both health care and rehabilitation services to be offered closer to their homes.

Respondents were particularly interested in physical rehabilitation. Consider the woman who reported having "malformations in the muscles" due to lack of rehabilitation. Another example is that of the child who was losing his mobility due to lack of physical therapy. As with other needs that were reported by the respondents, indigenous people with disabilities who live in rural areas appear to be particularly affected by the lack of physical rehabilitation services.

The majority of the respondents also reported that they needed to receive ***emotional support*** as well. This is true for all of the sub-groups such as urban and rural, male and female, and adults and children. A woman who had an amputation expressed this need very clearly when she wrote that she needed, "Psychological help so that we can accept how we are as amputees. Already, we have many traumas because of the fact that we lost a limb." For both children and urban adults (specifically, urban men), the need for emotional support was second only to the need for physical rehabilitation. For urban adult women, the need for emotional support was second only to the need for employment.

As regards access to vocational rehabilitation, assistance in the Mixteca region is non-existent. In fact, vocational rehabilitation as a profession is unknown in all of Mexico and very few rehabilitation services for adults exist. However, as the comments of respondents indicated, there is great interest among indigenous people with disabilities, and among their family members, for "specialized rehabilitation" and "vocational rehabilitation." Closely linked to vocational rehabilitation is employment. Both the quantitative and qualitative results demonstrate that among the adult respondents there was a need for employment. The data indicate that among all sub-groups, unemployment was the rule rather than the exception. For

example, 69% (63) of all adults, 57% (20) of urban adults, 77% (43) of rural adults, 63% (38) of men, and 81% (25) of women were unemployed. ***Even though the majority from each of these sub-groups is unemployed, one can not help noticing that there is a large disparity in unemployment rates between urban and rural adults as well as between men and women.*** This is very unfortunate when you consider that 66% of rural adults and 66% of women reported that one of their greatest needs was permanent employment. The comments given by both the men and women regarding employment demonstrate that there is not a lack of initiative or desire to work, but rather a lack of access to employment opportunities.

Perhaps the most stunning aspect of the survey results for United States audiences is the disparity between the lack of education and the reported need for education. For example, over three-quarters [77% (70)] of the adult respondents had no more than an elementary education; yet, only 42% of the adults reported education as one of their primary needs. This disparity is greater among rural adults than it is among urban adults, even though it holds true for both groups. Many of the comments from the adult respondents make a linkage between vocational rehabilitation and employment, but never between education and employment. Therefore, it seems that it is not only lack of access to an education, but also lack of perceived need that inhibited the adult respondents from getting more than an elementary school education.

However, this is not necessarily true for the school-age children. The majority of the school-age children who responded to this survey were not attending school. Yet, education was cited by the majority of them and/or their parents as one of their greatest needs. Unfortunately, the survey that was used for this study was not designed to measure the reasons for lack of

education; therefore, we are not able to say whether people with disabilities in the Mixteca region are not getting an education because they do not have physical access to the schools, or because there are no schools in their towns and villages. No matter what the reason for the lack of education among the indigenous people with disabilities in the Mixteca region, again, as with *Vecinos: Phase I*, Mungazi (1991) reminds us, "It is in the best interest of the international community itself to promote the educational development of all people" (p. 35). This may prove to be especially true for indigenous people with disabilities in the United States and Mexico given the new economic linkages that have been forming between the two countries.

Research Process and Dynamics

The results of this study, as did the results of the initial *Vecinos* research (Marshall, Gotto, Peréz Cruz, Flores Rey, & García Juárez, 1996), confirm that a participatory action research (PAR) strategy, coupled with a research design that calls for face-to-face interviews conducted by local people with disabilities, is the most effective means for assessing needs in an indigenous community. In utilizing a PAR strategy to guide research procedures, researchers commit to *action* following the collection and analysis of data. A first step of action involves returning the data collected from the community to the community in a usable format--a preferred format of AIRRTC researchers has been the community meeting or public forum. A community meeting to disseminate the initial results of the Mixteca research was held in Huajuapan de León on August 5 and 6, 1996 (see Appendices E - I). Recommendations for action resulting from this meeting are presented in Appendix I.

The Exchange of Knowledge and Skills

In comparing indigenous people from the United States to indigenous people from Mexico, Martha Johnson Gorospe, Project Director, Education for Parents of Indian Children with Special Needs (EPICS), stated, "Our people are extremely similar" (personal communication, August 27, 1996). Both the community-based researchers from Mexico and the university-based researchers from the United States have learned many valuable lessons from one another--lessons which will, hopefully, prove to assist the "extremely similar" indigenous people of both countries in meeting their rehabilitation needs. As a result of working with rehabilitation professionals from the United States, as a result of traveling to the United States, and as a result of talking with other people who have disabilities and who participated in the First Congress Regarding Disability in the Mixteca, the community-based researchers from the Mixteca region have learned a great deal about comprehensive rehabilitation programs, full accessibility for people with disabilities, and federal laws that guarantee the previous two items (see, e.g., Appendices F and G). Because they had never experienced vocational rehabilitation, complete accessibility, or laws such as the Americans with Disabilities Act, the indigenous people with disabilities from the Mixteca region did not realize what they could or should expect. Working with rehabilitation professionals, visiting rehabilitation programs in the United States, and talking with disability rights activists has helped them to set new goals.

The United States rehabilitation programs have much to learn from the indigenous people with disabilities from the Mixteca region as well. Typically, citizens in the United States, from community members to policy makers, have come to believe that all aspects of life should run smoothly, and

that, generally, "someone else" is responsible for ensuring that this is the case. Because United States citizens are fortunate that most aspects of our lives do run smoothly, or can be quickly corrected/repaired when something goes wrong (by paying someone!), we have lost a great deal of personal resourcefulness when we do not have the money to buy ourselves out of a bad situation. We have even lost the capacity to understand or cope with a difficult situation that may not have an immediate solution. As journalist John Hockenberry commented (1995):

> In the Middle East, day-to-day life was close to the experience of living in a wheelchair. This was not to say that being in the Third World was a crippling injury; rather, it was to go through life with the presumption that things were not going to go your way, an experience relatively rare in America and the industrialized world, but extremely common almost everywhere else. Whether it was taxes, the weather, a war, neighbors, or the infrastructure, no one in the Third World expected such things to go well. . . . The belief that around the next corner there was going to be some obstacle fit well into my own sense of the world acquired from a wheelchair (pp. 262-263).

Given the cutting of budgets at both the federal and state levels in the United States, rehabilitation programs and individuals with disabilities could learn a lot from the ingenuity of the indigenous people with disabilities in the Mixteca region. For example, the on-site coordinator and co-author of this paper, Ovaldo Galicia García, who is disabled due to polio, made his own crutches and wheelchair. Although we are aware that it is not realistic for all people with disabilities to make their own wheelchair, we feel that people in the United States can learn from this type of ingenuity and resourcefulness.

Another area in which the United States can learn from the people with disabilities in the Mixteca region, has to do with the involvement of the family and community in the life of the person with a disability (see, e.g., Appendix H). As we know, allowing the person with a disability to be an integral part of their family and community, rather than placing them in special homes, schools, and institutions, gives the person a sense of belonging and of home. More difficult for majority culture disability advocates and policy makers in the United States to understand is the need for indigenous families to maintain integral ties with their relative who has a disability--indeed with all relatives!

The information gained from this project, along with the information gained from *Vecinos: Phase I*, will form the basis of rehabilitation training curricula, useful to rehabilitation educators training counselors in cross-cultural counseling and in serving appropriately indigenous populations. The information will be used by *El Centro de Rehabilitación Integral*, in Oaxaca City and the *Asociación de Discapacitados de la Mixteca* in Huajuapan de León to develop their rehabilitation training curricula for remote rural communities. It will also provide more information for rehabilitation researchers who enable their subjects to participate in community action research. Specifically, researchers in the U.S. will learn how to best include culturally diverse indigenous people with disabilities through the rehabilitation research process.

CONCLUSIONS and RECOMMENDATIONS

The main purpose for collaborating in this investigation, according to on-site research coordinator, Ovaldo Galicia García, was to assess the need for a rehabilitation center in the Mixteca region of Oaxaca, Mexico, with its main

office located in Huajuapan de León. The mission of this center will be the availability of physical rehabilitation, psychological rehabilitation, and importantly, a center for vocational rehabilitation. In the words of Galicia García, "It is understood that vocational rehabilitation is a necessity for people with disabilities who want to be a productive part of the community. Rehabilitation is essential for people that yearn for professional development, but first we have to learn what they want to do, so we can encourage their development. We cannot consider people with disabilities to be rehabilitated unless they are integrated into the community. Only when people with disabilities become economically independent can they be considered totally integrated."

The on-site research coordinator met with the PAC in Huajuapan de León, Mexico on February 5, 1997, to report the final results of the research project. Following the presentation of results, the on-site coordinator and the PAC discussed the need and support base for a long-range rehabilitation research and training effort in Mexico; the PAC members reported that they felt there was a tremendous need for continued rehabilitation research and training. In fact, the Mayor of Huajuapan de León, who was a PAC member, was so concerned with the results that by February 28, 1997, he located funds to begin a comprehensive rehabilitation program in Huajuapan de León. As of the writing of this report, the Huajuapan rehabilitation program had hired a physical therapist and a psychologist. Currently, they are working to begin an education and vocational rehabilitation program for indigenous people with disabilities in the Mixteca region.

This outcome speaks volumes for the PAR model. As discussed earlier, indigenous people with disabilities from the Mixteca region were active participants in every major decision regarding the project; were

instrumental in the development of the survey instrument; directed the data collection and the data entry process; and assisted in the interpretation of the data and in the dissemination of the research results. The research described in this paper pointed out that persons with disabilities in the Mixteca region need: (a) increased access to health care; (b) physical rehabilitation services; (c) emotional support; and (d) increased education and employment opportunities, in particular, for indigenous people with disabilities in rural areas and for women with disabilities. The development of a comprehensive rehabilitation program in Huajuapan de León, the capital of the Mixteca region, will be a start towards meeting these needs. It is difficult to imagine that the outcome of this project would have been the same without the full participation of the indigenous people with disabilities.

However, the information gained through this study, and from future international studies, will be used not only to inform the local communities involved in the research of the needs and resources of people with disabilities, but will also serve to inform rehabilitation practitioners and educators of culturally-sensitive intervention and research procedures. For example, according to Lee (1991), "Research evidence must guide multicultural counseling practice. . . . Empirical evidence is needed to support ideas about the effectiveness of indigenous models of helping and culturally responsive counseling interventions in changing client attitudes, values, and behaviors" (p. 212).

Ultimately, it is also hoped that the information gained through this study will be used to inform policy makers, both in the United States and in Mexico, that rehabilitation intervention must accommodate the *cultural needs* of indigenous populations--needs which may be completely different than any experienced by the majority culture policy makers. Similarly, it is

hoped that the information gained through this study will inform policy makers that the rehabilitation intervention *accommodations* provided for indigenous populations may need to be completely different from any experienced or desired by majority culture policy makers. For example, in relating an experience of how he was not permitted access to a Broadway play, missed the performance, but successfully sued for access (after the show he had wanted to see had closed), journalist John Hockenberry (1995) commented, "In the Middle East, among Arabs or Jews, I would have encountered more steps and fewer lawyers, judges and wheelchair lifts, but I have no doubt that in Jerusalem I would have seen the show" (p. 263).

Recommendations

Research Process

As with *Vecinos: Phase I*, our bi-national and multicultural research team has learned many lessons about how to successfully complete an international research project that focuses on indigenous people with disabilities. Recommendations for future research include those from *Vecinos: Phase I* (Marshall, Gotto, Peréz Cruz, Flores Rey, and García Juárez, 1996), as well as additional recommendations contributed by on-site research coordinator Ovaldo Galicia García (see Recommendations #8 - 11).

1. Solicit the help of people who identify culturally with the community where the research is to be conducted.
2. Conduct a thorough training on data collection techniques and methodologies with those people who help collect the data in order to assure the validity of the final product. These training sessions should include topics such as confidentiality, the influence of the interviewer on the investigation, and the responsibilities of the interviewer.

3. Conduct a thorough training on data entry and analysis if you request this help from people who are not formally trained as researchers. For example, the Oaxacan members of the research team had no previous experience in data entry.
4. Pilot-test the survey instrument to make sure that it is appropriate and make modifications if necessary before the actual survey process commences.
5. Have copies of the survey instrument available in the Native language of the people who are being surveyed.
6. Have monthly meetings with all people who are helping to collect the data in order to evaluate the work, discuss doubts and problems, and to ensure that all interviewers are continuing to collect data in the same manner.
7. Establish a time limit for turning in all collected surveys so that data is not sitting around unprotected with the possibility of being lost or compromising a person's confidentiality.
8. Establish a minimal level of education or academic preparation for interviewers so that they can correctly carry out their responsibilities, for example, correctly spell and record qualitative data.
9. Include in the interviewer training information on how to correctly identify and record type of disability (given the person being interviewed does not know); if it is not possible for interviewers to identify a disability, they should be able to describe the parts of the body affected by the disability.
10. Similarly, inform interviewers that they may encounter a variety of different disabling conditions, such as physical, sensory, psychological, intellectual, etc. This will enable interviewers to collect precise data

from persons with a wider range of disabling conditions, rather than, simply, for example, only from persons with physical disabilities.

11. In presenting the results, including the final report, present the needs of children separately from those of adults in order to provide recommendations for children's programs independent of those needed by adults.

The Participating Community

The results of this research project, combined with the experience of working with indigenous people with disabilities on both sides of the border, led members of the research team to make the following recommendations in regard to the people and the community that took part in this research (see also Appendix I):

1. Aggressively seek opportunities to further the development of a comprehensive rehabilitation program for indigenous people with disabilities in the Mixteca region.
2. The people who do not have disabilities should know more about the living conditions of people with disabilities; and vice versa, the people with disabilities should work to educate those who don't have disabilities. We are sure that better understanding and cooperation bring equality.
3. Businesses should remember that people with disabilities can be as productive as people without disabilities, especially if you offer them adequate access.
4. The people with disabilities should look for existing support programs or consider creating support programs for themselves and other people with disabilities who find themselves in a similar situation.

5. Education, rehabilitation, and employment opportunities specifically focused on the needs of rural indigenous women with disabilities should be created.
6. Education, rehabilitation, and employment opportunities specifically focused on the needs of indigenous people with disabilities **in rural areas** should be created.
7. Support and information programs for the families of people with disabilities should be created.
8. In the words of Germán Pérez Cruz, when he spoke at the inauguration of an access ramp to the City of Oaxaca's administrative offices, "Work together to create a world in which it is more important to be human than to be 'normal,' a world in which war, poverty, and desperation do not contribute in creating more disabilities. A world where everyone is equal, with the same opportunities, with the same responsibilities, the same rights; in which everyone fights to create a world . . . a world that is more just, equal, and accessible . . . but most importantly . . . more humane."

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Appendix A

El Centro de Rehabilitación Integral

Figure 1

Intervention Objectives of the Center

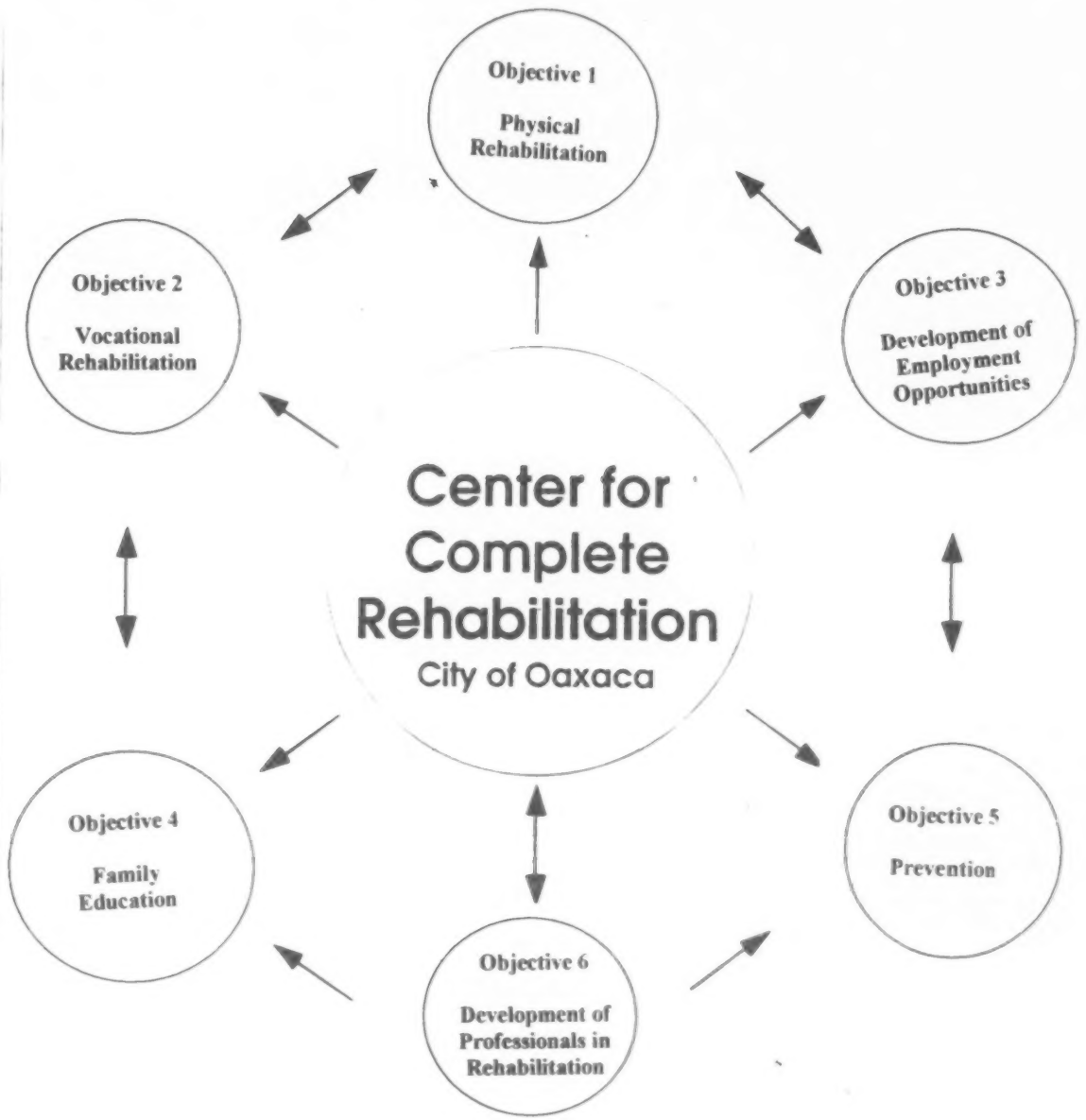
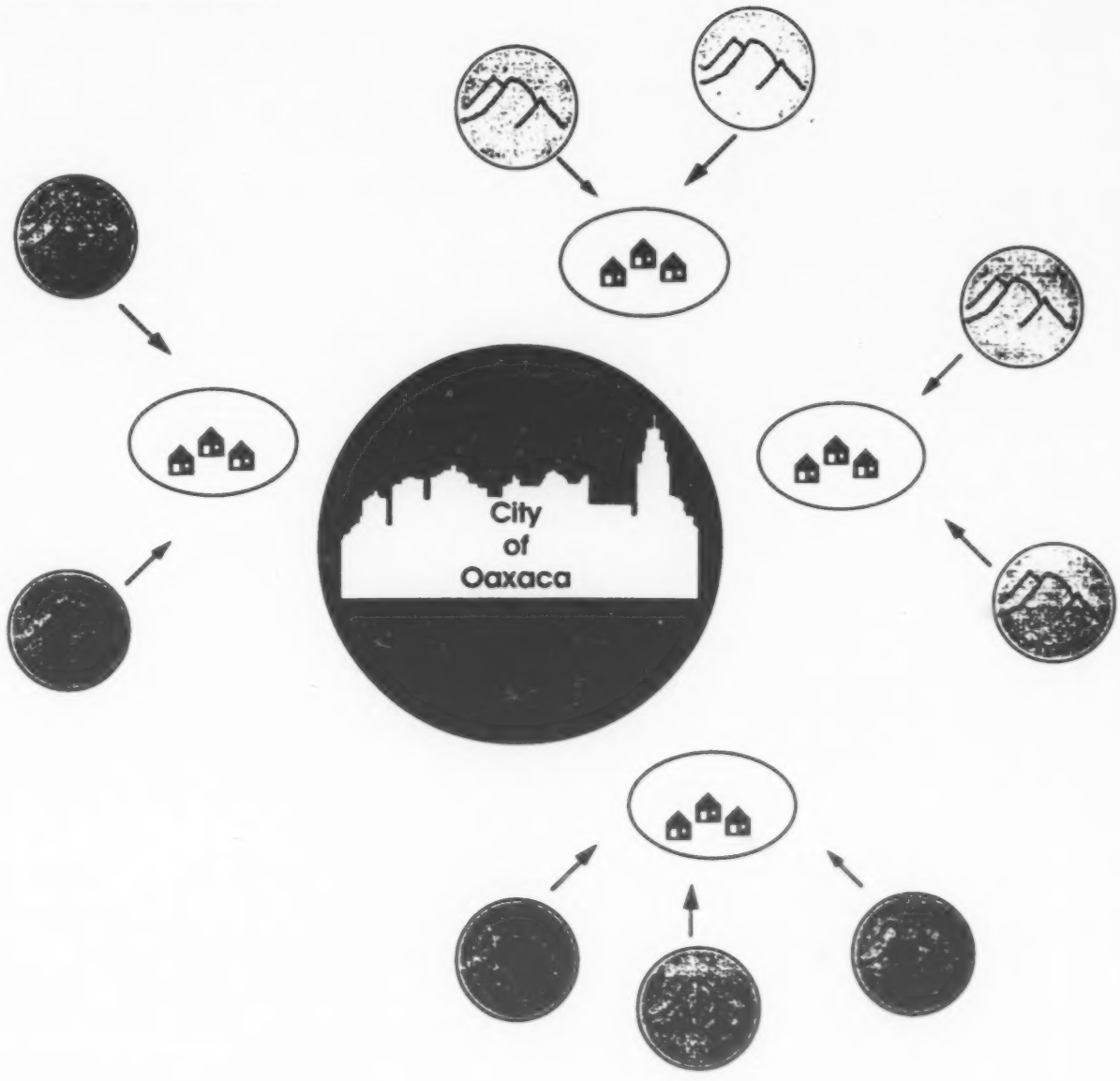


Figure 2

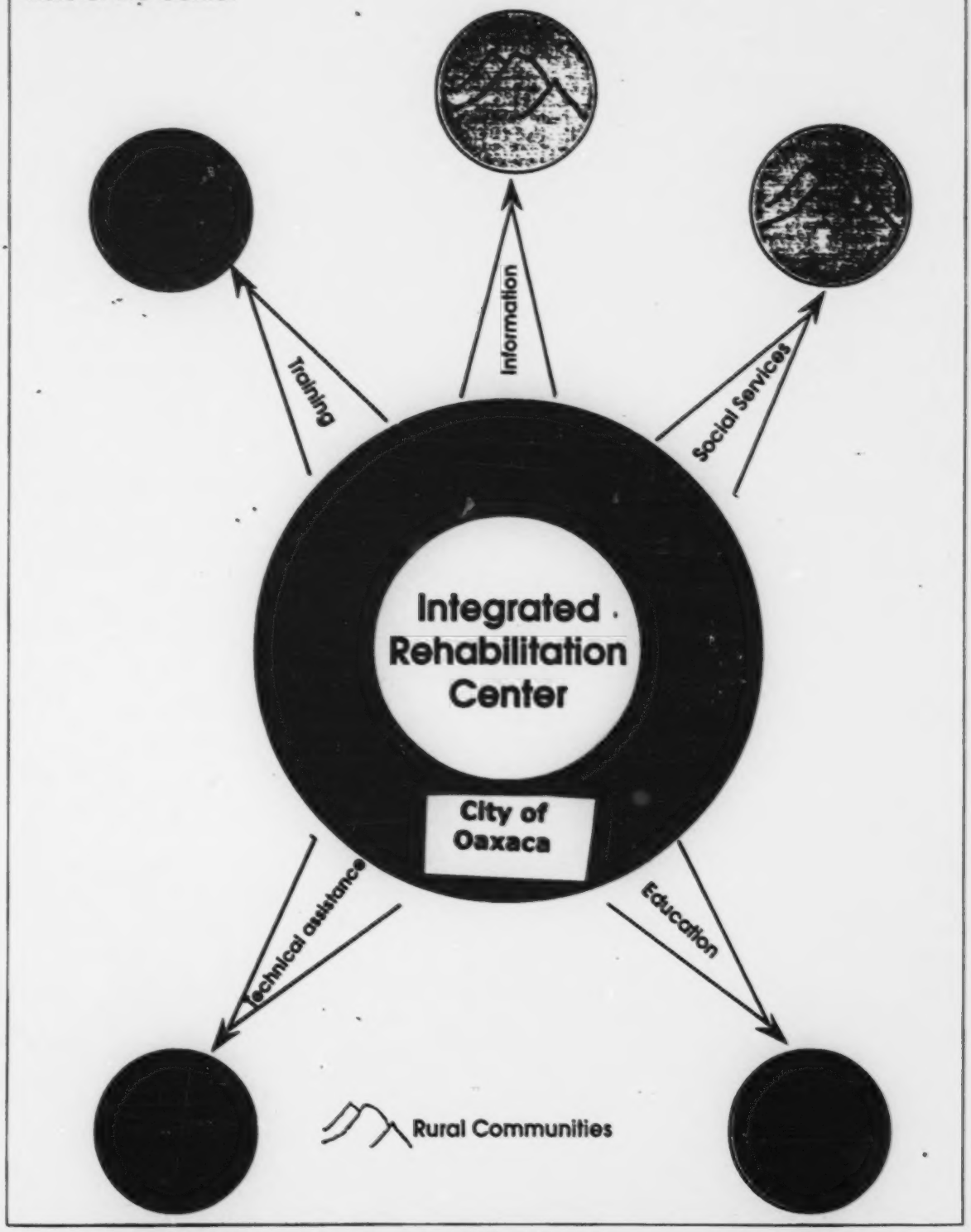
The Current Situation



The City of Oaxaca has health and social services. Rural disabled population immigrates to the City of Oaxaca, the capital of the state, looking for rehabilitation services, but they end up forming marginal communities outside the capital.

Figure 3

Role of the Center

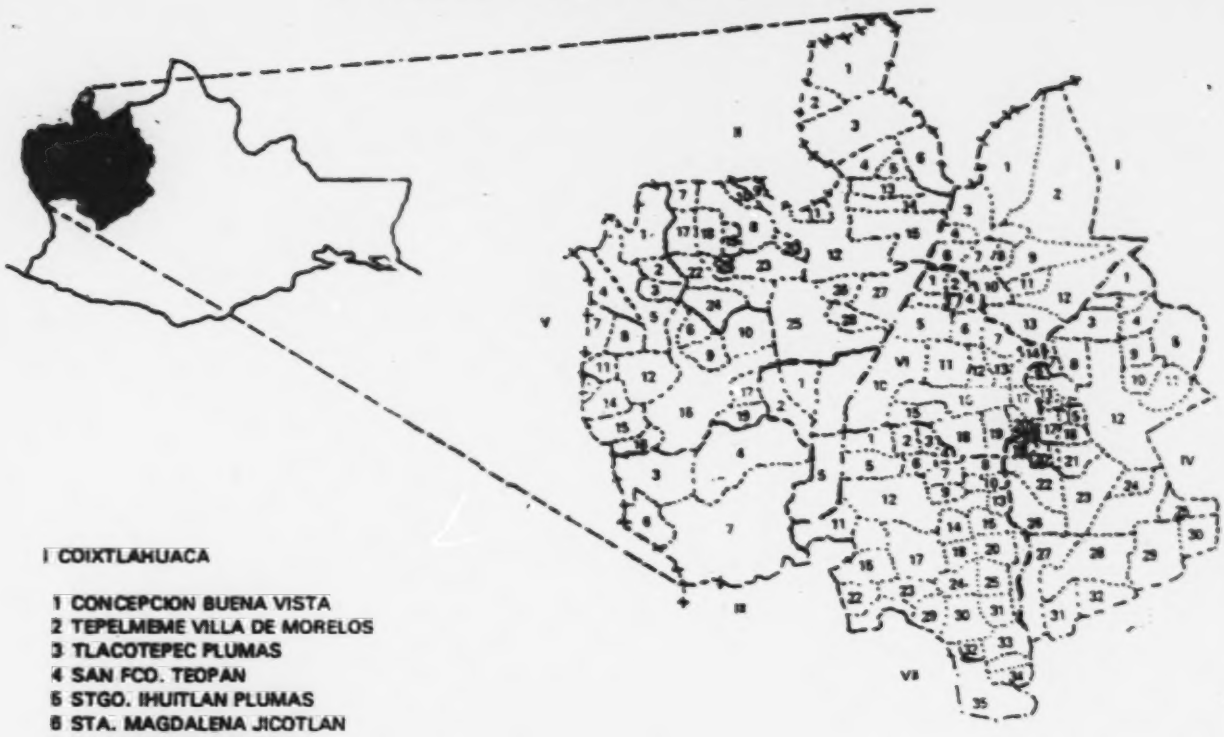


It is important to have adequate rehabilitation services available in the rural communities in order to avoid immigration to city slums.

Appendix B

The Mixteca Region, Oaxaca, Mexico

LOCALIZACION DE LA REGION MIXTECA



I COIXTLAHUACA

1 CONCEPCION BUENA VISTA
2 TEPELMEME VILLA DE MORELOS
3 TLACOTEPEC PLUMAS
4 SAN FCO. TEOPAN
5 STGO. IHUITLAN PLUMAS
6 STA. MAGDALENA JICOTLAN
7 SN. MATEO TLAPILTEPEC
8 SANTIAGO TEPETLAPA
9 SN. MIGUEL TEQUIXTEPEC
10 SN. MIGUEL TULANCINGO
11 SN. CRISTOBAL SUCHIXTLAHUACA
12 SN. JUAN BAUTISTA COIXTLAHUACA
13 STA. MARIA NATIVITAS

II HUAJUAPAN

1 STGO. CHAZUMBA
2 COSOLTEPEC
3 SAN PEDRO Y SAN PABLO Y SAN PEDRO Y SAN PABLO TEQUISTEPEC
4 SANTIAGO MILTEPEC
5 SAN JUAN BAUTISTA SUCHIXTEPEC
6 STA. CATARINA ZAPOQUILA
7 FRESNILLO DE TRUJANO
8 SAN MIGUEL AMATITLAN
9 SAN JOSE AYUQUILA
10 SANTIAGO AYUQUILA
11 ZAPOTITLAN PALMAS
12 HUAJUAPAN DE LEON
13 ASUNCION CUYOTEPEJI
14 SANTA MARIA CAMOTLAN
15 STGO. HUAJOLOTITLAN
16 SANTA CRUZ TACACHE DE MINA
17 MARISCALA DE JUAREZ
18 SAN MARTIN ZACATEPEC
19 SAN SIMON ZAHUATLAN
20 SAN JERONIMO SILACAYOAPILLA
21 SANTOS REYES YUCUNA
22 SANTO DOMINGO TONALA
23 SAN MARCOS ARTEAGA
24 SAN JORGE NUCHITA
25 TEZOATLAN DE SEGURA Y LUNA
26 SANTIAGO CACALOXTEPEC
27 SAN ANDRES DINICUITI
28 SANTO DOMINGO YODOHINO

III JUXTLAHUACA

1 SANTOS REYES TEPEJILLO
2 SAN MIGUEL TLACOTEPEC
3 SAN MARTIN PERAS
4 SAN SEBASTIAN TECOMAXTLAHUACA
5 SAN JUAN MIXTEPEC
6 COICOYAN DE LAS FLORES
7 SANTIAGO JUXTLAHUACA

IV NOCHIXTLAN

1 SAN MIGUEL HUAUTLA
2 SANTIAGO APOALA
3 SAN MIGUEL CHICAHUA
4 SANTA MARIA APAZCO
5 ASUNCION NOCHIXTLAN
6 SANTO DOMINGO YANHUITLAN
7 SANTA MARIA CHACHOAPAN
8 SAN JUAN YUCUITA
9 MAGDALENA ZAHUATLAN
10 SAN PEDRO CANTAROS COXCALTEPEC
11 SANTIAGO HUAUCLILLA
12 SAN ANDRES SINAXTLA
13 SANTIAGO TILLO
14 SAN JUAN SOYALTEPEC
15 SAN MATEO ETLATONGO
16 YODOCONO DE PORFIRIO DIAZ
17 SAN FRANCISCO CHINDUA
18 SAN MIGUEL TECOMATLAN
19 SAN MIGUEL TIDAA
20 SAN FRANCISCO NUXAÑO
21 SAN FRANCISCO JALTEPETONGO
22 SANTIAGO TILANTONGO
23 MAGDALENA JALTEPEC
24 ZARAGOZA

25 SAN ANDRES NUXIÑO
26 SAN JUAN DUIXI
27 SAN MATEO SINDIHUI
28 YUTANDUCHI DE GUERRERO
29 SN. JUAN TAMAZOLA
30 SANTO DOMINGO NUXAA
31 SAN PEDRO TEOZACALCO
32 SAN MIGUEL PIEDRAS

V SILACAYOAPAN

1 SAN JUAN CIENEGUILLA
2 SAN NICOLAS HIDALGO
3 GUADALUPE DE RAMIREZ
4 SAN JUAN IGUALTEPEC
5 SANTIAGO TAMAZOLA
6 SAN LORENZO VICTORIA
7 ZAPOTITLAN LAGUNAS
8 SAN MIGUEL AHUEHUETITLAN
9 SANTIAGO YUCAYACHI
10 SAN AGUSTIN ATENANGO
11 SAN ANDRES ATENANGO
12 SANTA CRUZ DE BRAVO
13 SAN MATEO NEJAPAN
14 SAN JUAN BAUTISTA TLACHICHILCO
15 SILACAYOAPAN
16 CALIHUALA
17 IXPANTEPEC NIEVES
18 SAN FRANCISCO TLAPANCINGO
19 SANTIAGO DEL RIO

VI TEPOSCOLULA

1 SAN PEDRO NOPALA
2 TRINIDAD VISTA HERMOSA
3 TEOTONGO
4 SAN ANTONIO ACUTLA
5 TAMAZULAPAM DEL PROGRESO
6 VILLA TEJUPAM DE LA UNION
7 SANTO DOMINGO TONALTEPEC
8 SN. SEBASTIAN NICANDUTA
9 S. ANTONIO MONTE VERDE
10 STA. MARIA CHILAPA DE DIAZ
11 SAN ANDRES LAGUNAS
12 SAN PEDRO YUCUNAMA
13 SAN JUAN TEPOSCOLULA
14 SAN BARTOLO SOYALTEPEC
15 SANTIAGO YOLOMECATL
16 SN. PEDRO Y SN. PABLO TEPOSCOLULA
17 SAN PEDRO TOPILTEPEC
18 SANTA MARIA NDUAYACO
19 SAN VICENTE NUÑU
20 SANTIAGO NEJAPILLA
21 SANTO DOMINGO TLATAYAPAM

VII TLAXIACO

1 SAN PEDRO MARTIR YUCUXACO
2 SAN JUAN NUMI
3 SAN MARTIN HUAMELULPAM
4 SANTA CRUZ TAYATA
5 SANTIAGO NUNDICHI
6 SANTA MARIA DEL ROSARIO
7 SANTA CATARINA TAYATA
8 SAN JUAN ACHIUTLA
9 SAN CRISTOBAL AMOLTEPEC
10 SAN MIGUEL ACHIUTLA
11 SAN MARTIN ITUNYOSO
12 SANTA MARIA ASUNCION
13 SAN BARTOLOME YUCUAÑE
14 MAGDALENA PEÑASCO
15 SAN AGUSTIN TLACOTEPEC
16 SANTO TOMAS OCOTEPEC
17 SANTA CRUZ NUNDACO
18 SAN ANTONIO SINICAHUA
19 SAN PEDRO MOLINOS
20 SAN MATEO PEÑASCO
21 SANTA MARIA TATALTEPEC
22 SANTA MARIA YUCUITI
23 SAN ESTEBAN ATATLAHUCA
24 SANTA CATARINA TICUA
25 SANTA MARIA YOSOYUA
26 SANTIAGO NUYOO
27 SAN JUAN TEITA
28 SANTA CATARINA YOSONOTU
29 SAN MIGUEL EL GRANDE
30 CHALCATONGO DE HIDALGO
31 SAN PABLO TIJALTEPEC
32 SANTO DOMINGO IXCATLAN
33 SANTA CRUZ TACAHUA
34 SANTA MARIA YOLOTEPEC
35 SANTIAGO YOSONDUA

Appendix C

Survey Instrument

DIRECCION GENERAL DE DESARROLLO SOCIAL
COMITE DE SALUD DEL FRENTE UNIDO DE DISCAPACITADOS
CEDULA DE IDENTIFACICION ACCESO LIBRE

La Mixteca

Instrucciones: Señale solo una respuesta para cada pregunta.

DEMOGRAFÍA

1a. Nombre _____

1b. Apellido (1) _____

1c. Apellido (2) _____

2. Domicilio Actual

2a. _____
Calle No.

2b. _____
Col. C.P.

3. Teléfono _____

4. Sexo ❑ Masculino ❑ Femenino

5. Fecha de Nacimiento ____/____/____
M D A

5a. Años Cumplidos _____

5b. En caso de desconocer su edad poner dato aproximado ____/____/____
M D A

6. Estado Civil
- ❑ Soltero (a)
- ❑ Casado (a)
- ❑ Viudo (a)
- ❑ Divorciado (a)
- ❑ Otro _____

7. Escolaridad: Grado último de estudios
- ❑ Sin Educación
- ❑ Primaria
- ❑ Secundaria
- ❑ Preparatoria
- ❑ Profesional

Especificar su profesión

_____

8. Ingresos Económicos ❑ Sí ❑ No

8a. ¿De donde vienen los ingresos económicos?
- ❑ Empleo
- ❑ Pensión
- ❑ Otro _____

8b. ¿Si está empleado, cual es su ocupación?

_____

9. Lugar de Origen

- ❑ Huajuapan de León
- ❑ San Marcos Arteaga
- ❑ Yucunuti
- ❑ Juquila de León
- ❑ Corral de Piedra
- ❑ Acatlima
- ❑ Llano Grande
- ❑ San M. Papalotitlan
- ❑ Rio Salado
- ❑ San Juan
- ❑ Yetla
- ❑ Teotongo
- ❑ San J. Silacayoapilla
- ❑ Santos Reyes Yucuna
- ❑ Tezoatlán de Segura y Laguna
- ❑ Santiago Cacaloytepec
- ❑ San Agustín Atenango
- ❑ La Trinidad V. Hermosa
- ❑ Santiago Huajolotitlán
- ❑ San Vicente
- ❑ El Naranjal
- ❑ Castillo
- ❑ Zapotitlán Palmas
- ❑ Sn. Sebastián
- ❑ Tutla
- ❑ Ocampo
- ❑ Tonalá
- ❑ San Pedro Nopala
- ❑ Sta. Ma. Camotlán
- ❑ Otro _____

10. Pertenece a algun grupo etnico:

- ❑ Amuzgo
- ❑ Chatino
- ❑ Chocho
- ❑ Huave
- ❑ Mazateco
- ❑ Mixteco
- ❑ Popolaca
- ❑ Zapoteco
- ❑ Cuicateco
- ❑ Chinanteco
- ❑ Chontal
- ❑ Ixcateco
- ❑ Mixe
- ❑ Nahuatl
- ❑ Triqui
- ❑ Zoque
- ❑ Otro _____

11. Depende alguien de usted:

❑ Sí ❑ No

11a. ¿Si contesta "Sí", cuantas personas depende de usted? _____

11b. ¿Depende usted de alguien?

❑ Sí ❑ No

DISCAPACIDAD

12. Tipo de lesión:

- ❑ Polio
- ❑ Amputación
- ❑ Debil Visual
- ❑ Sordo/Mudo
- ❑ Cuadraplejia
- ❑ Hemiplejia
- ❑ Autismo
- ❑ Epilepsia
- ❑ Problemas de Desarollo
- ❑ Malformaciones Congénitas
- ❑ Otro _____
- ❑ Paraplejia
- ❑ Ciego
- ❑ Paralisis Cerebral
- ❑ Distrofia Muscular
- ❑ Mielomeningocele
- ❑ Síndrome de Down
- ❑ Paralisis Infantil

13. Tiempo de lesión: _____ años.

14. Origen de la discapacidad:

- ❑ Secuela de enfermedad
- ❑ Accidente
- ❑ Congenito

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Instrucciones: Señale los que se relacione con su discapacidad.

15. ¿Que parte del cuerpo afecta la discapacidad?

- ❑ Miembros Inferiores
- ❑ Miembro Inferior Izquierdo
- ❑ Miembro Inferior Derecho
- ❑ Miembros Superiores
- ❑ Miembro Superior Izquierdo
- ❑ Miembro Superior Derecho
- ❑ Cerebral
- ❑ Visual
- ❑ Audición
- ❑ Habla
- ❑ Miembros Superiores e Inferiores
- ❑ Otro _____

16. ¿En el área donde vive existen recursos o instituciones para el apoyo de su discapacidad?

❑ Sí ❑ No

16a. ¿En caso de ser afirmativo cuales son?

- ❑ IMSS
- ❑ CREE
- ❑ Acceso Libre
- ❑ Ninguna
- ❑ SSA
- ❑ ISSSTE
- ❑ Instituciones Privadas
- ❑ Otro _____

COMENTARIO

17. ¿A su consideración cuales son las necesidades más urgentes para los discapacitados?

_____

_____

_____

_____

18. ¿Tiene alguna pregunta o desea hacernos alguna surgerencia para mejorar esta cédula de identificación?

_____

_____

_____

_____

19. A su consideración que tipo de apoyo necesita:

- ❑ Salud
- ❑ Empleo
- ❑ Rehabilitación
- ❑ Educación
- ❑ Apoyo psicológico
- ❑ Otro _____

Comentario:

_____

_____

_____

Solo para el que efectúa el censo:

20. Comentario personal:

_____

_____

_____

_____

_____

_____

_____

_____

INFORMES: Oficina de apoyo técnico Asociación de Discapacitados de la Mixteca A.C.
av. Hidalgo 205, C.P. 68000, Oaxaca, Oax.
Carretera Internacional 124, Colonia del Maestro
Huajuapan de León, C.P. 69000

TELEFONO: 2-15-65

Appendix D

PAC Letters of Support

NORTHERN ARIZONA UNIVERSITY

INSTITUTE FOR HUMAN DEVELOPMENT
UNIVERSITY AFFILIATED PROGRAM
AMERICAN INDIAN REHABILITATION RESEARCH AND TRAINING CENTER

Personas Con Discapacidades
Evaluación de las Necesidades en la Comunidad
Oaxaca, Mexico

Huajuapan de León, Oax., 19 de abril de 1996.

Confirmo mi participación como Integrante del Consejo de Evaluación y Apoyo del Proyecto de Investigación sobre Discapacidad en las areas Rurales aledañas a Huajuapan de León.

Esta Investigación se está llevando acabo en la región - bajo la dirección de la Asociación de Discapacitados de la -- Mixteca teniendo como responsable y Representante del Centro de Rehabilitación y Entrenamiento del Indigena Americano(AIRR TC) al Sr. Ovaldo Galicia Garcia.

Las metas de este Proyecto son:

1.-Llevar a cabo una evaluación de las necesidades, Prestación de Servicios y recursos de los Discapacitados en las areas rurales aledañas a Huajuapan de León.

2.-Establecer en Huajuapan un Centro de Rehabilitación-- Integral que de Servicio a toda la región Mixteca.

Manifiesto mi apoyo hacia este proyecto y mi dispocición de participar en los programas y actividades que de el resulten.

A T E N T A M E N T E .
SUFRAGIO EFECTIVO NO REELECCION
"RESPETO AL DERECHO AJENO ES LA PAZ"

PROF. [illegible] VILLALANA CASTILLEJOS
DELEGADO DEL GOBIERNO EN LA MIXTECA ALTA.

PO Box 5630 Flagstaff, AZ 86011-5630 (520) 523-4791 FAX (520) 523-9127 TDD (520) 523-1695

GONZALEZ GARCIA PERAL, S. A. DE C. V.
CONCESIONARIOS DE LA CERVECERIA MODELO, S. A. DE C. V.
Esq. 2 de Abril con Pedro Moreno, Col. La Merced
C. P. 69000, Apdo. Postal 58 Huajuapan de Leon, Oax.
Tels. (91-953) 2 23 45, 2 22 56, FAX 2 23 67

HUAJUAPAN DE LEON, OAX. A 19 DE ABRIL DE 1996.

CONFIRMO MI PARTICIPACION COMO INTEGRANTE DEL CONSEJO DE EVALUACION Y APOYO DEL PROYECTO DE INVESTIGACION SOBRE DISCAPACIDAD EN LAS AREAS RURALES ALEDAÑAS A HUAJUAPAN DE LEON.

ESTA INVESTIGACION SE ESTA LLEVANDO ACABO EN LA REGION BAJO LA DIRECCION DE LA ASOCIACION DE DISCAPACITADOS DE LA MIXTECA, TENIENDO COMO RESPONSABLE Y REPRESENTANTE DEL CENTRO DE REHABILITACION Y ENTRENAMIENTO DEL INDIGENA AMERICANO (AIRA TO) AL SR. OVALDO GALICIA GARCIA.

LAS METAS DE ESTE PROYECTO SON..

1. LLEVAR A CABO UNA EVALUACION DE LAS NECESIDADES, PRESTACION DE SERVICIOS Y RECURSOS DE LOS DISCAPACITADOS EN LAS AREAS RURALES ALEDAÑAS A HUAJUAPAN DE LEON.

2. ESTABLECER EN HUAJUAPAN UN CENTRO DE REHABILITACION INTEGRAL QUE DE SERVICIO A TODA LA REGION MIXTECA.

POR LO ANTERIOR MANIFIESTO MI APOYO HACIA ESTE PROYECTO, Y MI DISPOSICION DE PARTICIPAR EN LOS PROGRAMAS Y ACTIVIDADES QUE DE EL RESULTEN.

ATENTAMENTE

RAMON GONZALEZ PEREZ.

BEST COPY AVAILABLE

H. Ayuntamiento Constitucional
HUAJUAPAN DE LEON,
OAXACA

Dependencia	PRESIDENCIA MUNICIPAL
	ADMINISTRATIVA
Sección	
Núm. de Oficio	0160/96
Expediente	

ASUNTO: El que se indica

Huajuapan de León, Oax., abril 20 de 1996.

A QUIEN CORRESPONDA.
UNIVERSIDAD DEL NORTE DE ARIZONA

Confirmo mi participación como Integrante del Consejo de Evaluación y Apoyo del Proyecto de Investigación sobre Discapacidad en lar áreas Rurales aledañas a Huajuapan de León.

Esta Investigación se está llevando a cabo en la región bajo la dirección de la Asociación de Discapacitados de la Mixteca teniendo como responsable y representante del Centro de Rehabilitación y Entrenamiento del Indígena Americano (AIR RTC) al Sr. *Ovaldo Galicia García.*

Las metas de este Proyecto son:

1.-Llevar a cabo una evaluación de las necesidades, Prestación de Servicios y Recursos de los Discapacitados en las áreas rurales aledañas a Huajuapan de León.

1.-Establecer en Huajuapan un Centro de Rehabilitación Integral que de Servicio a toda la Región Mixteca.

2.-Por lo anterior manifiesto mi disposición de participar en los programas y actividades que de él resulten.

Atentamente
SUFRAGIO EFECTIVO. NO REELECCION
"EL RESPETO AL DERECHO AJENO ES LA PAZ"

H. AYUNTAMIENTO CONSTITUCIONAL HUAJUAPAN DE LEON, OAX.

LIC. GUADALUPE MARTINEZ
Presidente Municipal Constitucional.

c.c.p.- Archivo

H. Ayuntamiento Constitucional
HUAJUAPAN DE LEON,
OAXACA

Dependencia	PRESIDENCIA MUNICIPAL HUAJUAPAN DE LEON,OAX.
Sección	D.I.F. MUNICIPAL
Núm. de Oficio	137
Expediente	

ASUNTO: EL QUE SE INDICA

Huajuapan de León,Oax.,20 de abril de 1996

CENTRO DE INVESTIGACION Y
ENTRENAMIENTO AL INDIGENA AMERICANO

Por medio del presente confirmo mi participación del Consejo de Evaluación y Apoyo del Proyecto de Investigación sobre Discapacidad en las areas Rurales aledañas a Huajuapan de León.

Esta investigación se está llevando a cabo en la región baja , la dirección de la Asociación de Discapacitados - de la Mixteca, teniendo como responsable y representante del -- Centro de Rehabilitación y Entrenamiento del Indigena Americano (AIRRTC) al Sr.Ovaldo Galicia Garcia.

Las metas de este Proyecto son:

1.-Llevar a cabo una evaluación de las necesidades, presentación de servicios y recursos de los Discapacitados en las areas rurales aledañas a Huajuapan de León.

2.- Establecer en Huajuapan un Centro de Rehabilitación Integral que de servicio a toda la región Mixtaca.

Por lo anterior manifieto mi disposición de participar en los programas y actividades que de el resulten.

D.I.F. MUNICIPAL

A T E N T A M E N T E
SUFRAGIO EFECTIVO.NO REELECCION
"EL RESPETO AL DERECHO AJENO ES LA PAZ"
LA PRESIDENTA DEL D.I.F.MPAL.

HUAJUAPAN DE LEON, OAX.

LIC.MA.CONCEPCION SANCHEZ LOYOLA

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BEST COPY AVAILABLE

Dirección General de CULTURAS POPULARES
UNIDAD REGIONAL HUAJUAPAN

DEPENDENCIA: DIRECCION GENERAL DE CULTURAS POPULARES, UNIDAD REGIONAL HUAJUAPAN

NUMERO DE OFICIO:

ASUNTO:

HUAJUAPAN DE LEON, OAX. A 15 DE ABRIL DE 1996

A QUIEN CORRESPONDA

LA QUE SUSCRIBE, SOC. GRISELDA GALICIA GARCIA, JEFE DE LA UNIDAD REGIONAL DE CULTURAS POPULARES EN LA MIXTECA, MANIFIESTA QUE CONOCE Y COLABORA CON EL PROYECTO DE LA ASOCIACION DE DISCAPACITADOS DE LA MIXTECA, EN CALIDAD DE INTEGRANTE DEL CONSEJO DE EVALUACION Y APOYO DEL PROYECTO DE INVESTIGACION SOBRE DISCAPACIDAD EN LAS AREAS RURALES DEL MUNICIPIO DE HUAJUAPAN DE LEON, OAX. RECONOCIENDO COMO RESPONSABLE Y REPRESENTANTE DEL CENTRO DE REHABILITACION Y ENTRENAMIENTO DEL INDIGENA AMERICANO (AIRRTC) AL SR. OVALDO GALICIA GARCIA

ASI MISMO, COMPRENDO QUE LA INTEGRACION DEL DISCAPACITADO A UNA VIDA SOCIAL Y PRODUCTIVA PLENA, IMPLICA NECESARIAMENTE EL RECONOCIMIENTO DEL PROBLEMA PARA OFRECER ALTERNATIVAS, POR LO QUE COINCIDO CON LOS OBJETIVOS DEL PROYECTO:

LLEVAR A CABO UNA EVALUACION DE LAS NECESIDADES, PRESTACION DE SERVICIOS Y RECURSOS DE LOS DISCAPACITADOS EN LAS AREAS RURALES DEL MUNICIPIO DE HUAJUAPAN.

ESTABLECER UN CENTRO DE REHABILITACION INTEGRAL QUE DE SERVICIO A TODA LA REGION MIXTECA

SIN OTRO PARTICULAR, ME SUSCRIBO COMO SU SEGURA Y CORDIAL SERVIDORA.

ATENTAMENTE

SOC. GRISELDA GALICIA GARCIA
JEFE DE LA UNIDAD REGIONAL DE CULTURAS POPULARES

C.c.p. archivo

NORTHERN ARIZONA UNIVERSITY

INSTITUTE FOR HUMAN DEVELOPMENT
UNIVERSITY AFFILIATED PROGRAM
AMERICAN INDIAN REHABILITATION RESEARCH AND TRAINING CENTER

Personas Con Discapacidades
Evaluación de las Necesidades en la Comunidad
Oaxaca, Mexico

C.DR.RAUL PALMA GUZMAN
DIRECTOR DEL HOSP.GRAL.DE LA S.S.
HUAJUAPAN DE LEON, OAXACA.

Confirmo mi participación como integrante del Consejo de Evaluación y Apoyo del Proyecto de Investigación sobre Discapacidad en las areas Rurales aledañas a Huajuapan de León.

Esta Investigación se está llevando acabo en la región - bajo la dirección de la Asociación de Discapacitados de la -- Mixteca teniendo como responsable y representante del Centro de Rehabilitación y Entrenamiento del Indigena Americano(AIRR TC) al Sr. Ovaldo Galicia Garcia.

Las metas de este Proyecto son:

1.-Llevar a cabo una evaluación de las necesidades, Prestación de Servicios y recursos de los Discapacitados en las areas rurales aledañas a Huajuapan de León.

2.- Establecer en Huajuapan un Centro de Rehabilitación-Integral que de Servicio a toda la región Mixteca.

Manifiesto mi apoyo hacia este proyecto y mi dispocición de participar en los programas y actividades que de el resulten.

A T E N T A M E N T E .
EL DIRECTOR DEL HOSPITAL GRAL.

C.DR. RAUL PALMA GUZMAN.

PLANTA EJECUTIVO FEDERAL
MEXICO, D.F.
SERVICIOS COORDINADOS DE SALUD PUBLICA EN EL ESTADO DE OAXACA
HOSPITAL GENERAL
HUAJUAPAN DE LEON, OAX.

PO Box 5630 Flagstaff, AZ 86011-5630 (520) 523-4791 FAX (520) 523-9127 TDD (520) 523-1695

ABRIL 19 DE 1996.

GUILLERMINA GONZALEZ GARCIA.
JAZMIN ESQ. ORQUIDEA
FRACC. JARDINES DEL SUR.
HUAJUAPAN DE LEON, OAX.

CONFIRMO MI PARTICIPACION COMO INTEGRANTE DEL CONSEJO DE EVALUACION Y APOYO DEL PROYECTO DE INVESTIGACION SOBRE DISCAPACIDAD EN LAS AREAS RURALES ALEDAÑAS A HUAJUAPAN DE LEON.

ESTA INVESTIGACION SE ESTA LLEVANDO ACABO EN LA REGION BAJO LA DIRECCION DE LA ASOCIACION DE DISCAPACITADOS DE LA MIXTECA, TENIENDO CMO RESPONSABLE Y REPRESENTANTE DEL CENTRO DE REHABILITACION Y ENTRENAMIENTO DEL INDIGENA AMERICANO (AIRR TC) AL SR. OVALDO GALICIA GARCIA.

LAS METAS DE ESTE PROYECTO SON..

.. LLEVAR A CABO UNA EVALUACION DE LAS NECESIDADES, PRESTA-- CION DE SERVICIOS Y RECURSOS DE LOS DISCAPACITADOS EN LAS AREAS RURALES ALEDAÑAS A HUAJUAPAN DE LEON.

.. ESTABLECER EN HUAJUAPAN UN CENTRO DE REHABILITACION INTE-GRAL QUE DE SERVICIO A TODA LA REGION MIXTECA.

POR LO ANTERIOR MANIFIESTO MI APOYO HACIA ESTE PROYECTO, Y MI DISPOCISION DE PARTICIPAR EN LOS PROGRAMAS Y ACTIVIDADES QUE DE EL RESULTEN.

ATENTAMENTE

GUILLERMINA GONZALEZ GARCIA.

BEST COPY AVAILABLE

PSQ. OSCAR RAMIREZ CARIÑO
DIRECTOR DE COMUNICACION SOCIAL
H. AYUNTAMIENTO.
P R E S E N T E .

Confirmo mi participación como integrante del Consejo de Evaluación y Apoyo del Proyecto de Investigación sobre Discapacidad en las areas Rurales aledañas a Huajuapan de León.

Esta Investigación se está llevando acabo en la región-- bajo la dirección de la Asociación de Discapacitados de la - Mixteca teniendo como responsable y representante del Centro de Rehabilitación y Entrenamiento del Indigena Americano(AIRR TC) al Sr. Ovaldo Galicia Garcia.

Las metas de este Proyecto Son:

1.-Llevar acabo una evaluación de las necesidades, Prestaciones de Servicios y recursos de los Discapacitados en las areas rurales aledañas a Huajuapan de León.

2.-Establecer en Huajuapan un Centro de Rehabilitación - Integral que de Servicio a toda la región Mixteca.

Por lo anterior manifiesto mi apoyo hacia este proyecto- y mi dispocición de participar en los programas y actividades que de el resulten.

A T E N T A M E N T E .

OSCAR RAMIREZ CARIÑO
DIRECTOR DE COMUNICACION SOCIAL
DEL H. AYUNTAMIENTO HUAJUAPAN DE LEON.

Appendix E

First Congress Regarding Disability in the Mixteca:
Community Meeting Agenda

AGENDA DE ACTIVIDADES

PRIMER CONGRESO SOBRE DISCAPACIDAD EN LA REGION MIXTECA
ASOCIACION DE DISCAPACITADOS DE LA MIXTECA A. C. Y.
UNIVERSIDAD DEL NORTE DE ARIZONA

AGOSTO 5 1996

9:00 a 9:30	Inauguración
9:30 a 10:45	Bienvenida por Ovaldo Galicia, Pdte. de la Asociación de Discapacitados de la Mixteca, A.C.
	PONENTES
10:45 a 11:30	Jorge Pineda, Asociación Nacional de Discapacidades de Desarrollo
11:30 a 12:00	Germán Pérez Cruz, Pdte. de Acceso Libre A.C. de Oaxaca
12:00 a 12:15	Receso.
12:15 a 13:00	La Familia y el Discapacitado
	PONENTES
	Ma. Elena Sandoval De Reyes (Madre) Aurora Sánchez González (Esposa) Raquel Mendez Huerta (Hija)
13:00 a 14:00	George Gotto y Catherine Marshall, Investigadores de la Universidad del Norte de Arizona
14:00 a 16:00	Comida
16:00 a 16:45	Juan Arelí Bernal Alcántara, Director de la Universidad Indígena de Totontepec, Mixe
16:45 a 18:00	Crónicas
	Nicasio Mendez Pérez Lorenzo Michaca Meza Victalina García López

18:00 a 18:30	Maria Teresa Arias Diaz, Presidenta de la Asociación de Sordos y Silentes de Oaxaca
18:30 a 19:00	Miriam Gabriela García Juárez, Presidenta de la Asociación de Mujeres Discapacitadas de Oaxaca
19:00	Recepción

AGOSTO 6 1996

9:00 a 11:00	Mesas Redondas de Discusión y Análisis Sobre - Diversos Temas
11:00 a 13:00	Programa Social y Cultural Clausura

Huajuapan de León, Oaxaca, Agosto de 1996.

Appendix F

First Congress Regarding Disability in the Mixteca:
Jorge Pineda

First Congress Regarding Disability in the Mixteca

Jorge Pineda

Translator: Leticia Green

My wife tells me that when she was born in the 1940s, the United States didn't have any laws to protect the rights of the people with disabilities. Millions of people with disabilities were suffering because of different forms of daily discrimination. The children were not allowed to attend school or they were sent to segregated schools. They were not taught the same subjects as the children without disabilities. The majority of the states didn't have laws that required buildings to be accessible. Buses and trains were not accessible. The street corners didn't have curb cuts. Many people with disabilities were discriminated against when they tried to find a job and there was no law stating that this practice was unlawful. If you were poor, there wasn't a national law that entitled you to medical attention or any financial aid to help you live. Housing was not accessible and there wasn't a law to prohibit discrimination against a person who wanted to travel by airplane. If the owners of a restaurant didn't want to serve you, they didn't have to do it. The bathrooms were not accessible. Basically, the persons with disabilities and their families confronted these problems very often.

After World War II, for the first time, the war veterans that survived this and other wars began to experiment how to live with spinal cord injuries and other disabilities. These veterans had an organization that began to fight for the rights for accessibility at the state level. Groups of persons who were blind and deaf started to fight for their rights, and also there were organizations of parents that started to fight for their children's rights.

These organizations began informing the American public, the Senators, and state representatives about the problems that persons with disabilities were facing. These organizations began to be created in all the United States at a local level within their community. They were fighting for many different things. Some of them were fighting to eliminate the architectural barriers, others fighting for the closing of the institutions for persons with disabilities, others were fighting for education.

Different laws were established at the state level. Some of these laws demanded that all the new buildings that were built should be accessible, other laws required that the public transportation should be accessible, some other laws prohibited the discrimination against children with disabilities in the public schools. These were very important laws. Many organizations were representing only the needs for certain types of disabilities, as an example, organizations for persons who are blind and for persons with mental retardation.

The development of centers for independent living were observed during the 1970s. These organizations believed that it was very important for people with different types of disabilities to work together. They also believed that they had to fight not only for new laws but also for services to help people with disabilities live more independently. The first center for independent living was funded in Berkeley, California in 1972. These organizations fought for a new legislation but they also created services to help people with disabilities to find a place to live, to find people to visit their home and to help them get out of bed, do the shopping, and help them to take a bath and to cook. They created services to repair wheel chairs and to help people with disabilities to find a job.

All these activities were very important. The people with disabilities began to work together and they began to talk about the type of federal laws that were necessary to protect their rights. The people with disabilities worked for many decades and gained strength to fight for these changes. In the mid 1980s, the people with disabilities felt they were ready to struggle for the approval of another very important law that prohibits discrimination against people with disabilities in the United States. This law was later referred to as the Americans with Disabilities Act, translated from English as the *Ley para Personas con Discapacidades.*

In December, 1975, in Washington, DC, a law called the Education for All Handicapped Children's Act was approved. This law was the result of many years of struggle. National organizations representing parents, educational organizations, and the defenders of the rights of people with disabilities, worked with the Congress of the United States. These organizations worked to document the problems that the children with disabilities and their families were confronting. Before this law was approved, at least one million children with disabilities couldn't attend the public schools. There were also a million children that were attending public schools, but they were placed in segregated classrooms and the educational level was not the same as other programs. There were several lawsuits representing the persons with mental retardation, who were living in institutions and were denied their right to live within their communities and also to receive education. There were some states that were providing very low quality services to the children, especially children with mental retardation and in the United States, if someone had a disability, many states did not believe that they had to provide the same educational services offered to the children without disabilities.

There were several meetings and studies and the Congress met with some experts to discuss the reason why it was necessary to have a federal law. As a result of this effort, legislation was written to end the discrimination in the educational sector. The Congress specified in this law that if any of the states agreed to the specifications of IDEA, the federal government would offer some financial assistance to help with the cost of education for these children.

This law, for the first time, guaranteed the right for appropriate and free public education for every child with a disability and who needed special education. The law also stated that the children should receive this education in the "least restrictive environment." That meant that the school district should guarantee that the child would attend the neighborhood school. If the child needs assistance, this assistance should be provided by the school district. This law also requires that every child has an Individualized Education Plan. To assure that the child does well in school, this individualized plan will be revised at least once a year and it is the document that will indicate the type of assistance that the child requires, including technology. The mother or father must be involved in the development of this plan.

At the present, all children attend school. With time, more children with disabilities attend school in their neighborhoods and they are learning in classes with children without disabilities. Studies indicate that children with disabilities are making great progress in school. Some people ask if the children who don't have disabilities have been negatively affected by the children with disabilities in their class. Our research indicates that this is not true. Our research reveals that both the children with disabilities and without disabilities have benefited since they began to study together. They

are learning about one another and how to respect and help each other. Also, we are observing that the children with disabilities are advancing because they are learning more, academically and socially. Our research also shows that more people with disabilities are finding jobs and more people with disabilities are attending universities. One of the most important results of this law is that the parents are participating more each day in the education of their children and also they have higher expectations for the future of their children.

Appendix G

First Congress Regarding Disability in the Mixteca:
Personal Histories
Nicasio Mendez Pérez,
Lorenzo Michaca Meza,
Victalina García López

First Congress Regarding Disability in the Mixteca: Personal Histories

Nicasio Mendez Pérez

Transcriber and translator: Joyce Y. García

A very good afternoon to a most respected public who honor us by being present here today. My name is Nicasio Méndez Pérez. I was born on 11 October, 1955 and I'm from the town of Tlacotepec de Juárez, Puebla. My parents are Don Telesforo Méndez Zepeda, farmer, and Doña Severiana Pérez Méndez, occupation: housewife.

I'm going to tell you about my personal life from childhood to adulthood. I became ill with poliomyelitis at the age of 3 years and my most serious problem was to face society because my parents and family in general wouldn't allow me to leave the house, that is to say, go out in public. But I had to face reality and I was living a life of whatever happened and whatever came my way and I had to roam various states of Mexico: Oaxaca, Vera Cruz, Mexico, Querétaro and Puebla. I went to all those places but without any support from my family. I found people who supported me and others who didn't because of my disability--they would tell me that I couldn't work. They would reject me and ignore me and I wandered a lot until I found a place where I found my future and that was here in Huajuapan where I've been living for 20 years. It's where I found my wife.

I have eight children and I have created my own sources of work and for other people, other friends who happen to have a disability. I currently share what God gives me with four friends whom I support in every way, physically, economically and spiritually. I feel very comfortable with them, to

be able to help them. My friends don't get discouraged. You have to make it in life, nothing is impossible. You can accomplish whatever you want. My friends with disabilities, you have to struggle in order to make it and work very enthusiastically. I make this invitation because I'm someone who feels good at this point.

As I've said friends, we may have feet that don't work, but our brains are fine and thank God I've been able to make it. Thank you, thank you very much. Your friend always, Nicasio Mendez Pérez

Lorenzo Michaca Meza

Transcriber and translator: Joyce Y. García

Good afternoon ladies and gentlemen, distinguished guests. I would like to welcome you to Huajuapan de León, Oaxaca. As you all know, the main purpose of our meeting is to converse in a clear and simple way about the different types of disabilities that each one of us unquestionably has. Fortunately, we have been able to come to the forefront in a dignified, conscientious manner. It is for me in particular, reason to reflect upon this subject since as you shall see, I was not born this way. It was destiny, because after having enjoyed a full life as far as my mobility, a serious accident came along to change my normal activities.

The process of this change was quite painful, physically as well as mentally. But in this case, no one knows where we get the strength to go forward. Of course, the therapy was truly helpful in this regard. I remember that beside me was a disabled person who had lost all mobility in his legs and he only used his hand to be able to move in a wheelchair. And he, though he had more injuries than I did, encouraged me to continue on.

He was really a great example to me of human courage. Certainly when you lose some mobility after having had it, it's more painful, I think, than when you're born without them because in this case you have to completely modify the lifestyle you've had. Furthermore you have to endure the morbid looks which single us out as different. That's why it's wise to say it in the presence of this Association--when you see a person with a disability, don't frighten them with persistent looks of pity. That's what really is a pity.

I would also invite this entire group that currently enjoys full mobility to value it dearly because when you lose your mobility you realize how much you had when you now face constant adversity due to limitations. But it's also very true that upon reflecting in this way, we are further challenged to reshape our way of thinking for the rest of our lives.

Victalina García López

Transcriber and translator: Joyce Y. García

Good afternoon friends. I'm Victalina García López. I'm participating by working and struggling on my own. I had polio as a newborn when I couldn't walk. I was always just sitting down. I felt sad because I could see that everyone around me was walking on their own and I never did that. So, then from there, I left. I asked my sister to help me with that because I wanted to take care of myself. Then that was when my sister thought to take me to a hospital when I was thirteen. That's when I had surgery. It helped so that I could walk and now, thanks be to God with [braces] which were given to me, well I can walk and do things for myself and that's when I feel the happiest. Why? Because then I feel like everybody else. So then my mother, precisely when I began to walk, my mother became very happy because then I could do anything they told me to. Then I began to work, I started to look for work. When I started to look for work, they, the people where I would go, wouldn't hire me. That is, they would tell me that I would never be able to work. And I really didn't believe it at all. So I began to think and told them, you know, you can see that I'm a person with a disability, well I'm more capable than you who are not disabled. And up to now, well I'm grateful to our friends because they've done a lot for us. I've told the friends to continue on, not to get left behind so they won't feel sad the way I did. So then they, whatever I've told them, they've always followed through because really, they're not like I was saying you know.

And at this point I feel at peace, I feel good and I want to continue on so that I can support my two children so that they can see that even though I'm this way, I can make it with them. That's all. Thank you.

Appendix H

First Congress Regarding Disability in the Mixteca:
The Family and Disability
María Elena Sandoval de Reyes,
Aurora Sánchez González,
Raquel Mendez Huerta

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First Congress Regarding Disability in the Mixteca:
The Family and Disability

María Elena Sandoval de Reyes

Transcriber and translator: Joyce Y. García

I'm María Elena Sandoval de Reyes at your service. I belong to, am a member of the Committee of the Asociación de Discapacitados de la Mixteca and I have a child with a disability of whom I am very proud. Right now, he's going to be eleven and really as a mother, well, I'd like to tell you about the few years, eleven years that I've lived this experience. But more than anything, I'd like to concentrate on something very short and simple. Sometimes the day to day experiences that you have begin when you know since the child's birth--when you're really told about the problem. I mean, sometimes you expect a perfect, ideal child just as you had always imagined. But well, many times we don't know how to value what life really is. And then when you're told that, well, that our child is born with some limitation, with something that, really, I don't know, that we could not imagine, it's difficult at that time to accept, I mean it's hard for you to assimilate. Really, often times you don't even know what to do or who to go to, or, or even what will come later.

But to begin my story, when I found out that my son had a congenital problem and really, the doctor didn't know how to give us the exact diagnosis. He just told us to take him to a specialist to see what he would tell us. And really, it's so difficult when you encounter doctors who sometimes, who do not observe professional ethics enough to say what they should. When sometimes they tell you that, well, that nothing can be done, that they can't

do anything or that your child won't live very long. The doctors say many things. And well, all those things are really very hard, I mean, at the time, they're very hard. But in time you start becoming more aware and you see things just as they are and how you have to face everything. If we have a problem on our hands, well we have to solve it, we have to see how we can solve our problems. So then, with my son, I've had a lot. At the beginning it is very hard to assimilate, but in time you start getting used to it, getting used to the problems that really sometimes you encounter on a daily basis.

Well, he had many, many operations since he was very small and even now he has to have some other operations and he continues to receive medical treatment. I mean, the biggest problem that I had to face was when . . . There are physical and social problems, as well as problems with morale. I have faced them all with my husband, with my family, and with the help of all of them and thanks be to God, well, we've been able to make it. Above all, we've been able to help our son make it. Now he's in sixth grade; he goes to a school, well, it's public really. It was really hard work to get him into a public school because since he was four, he was on the [?]--to attend kindergarten. Well I would say to myself how can I take him? How will he go to school?

And that wasn't the biggest problem, but rather the biggest problem was when I went to a kindergarten and told them about the problem that my son didn't walk, that my son required a wheelchair to be able to move about, then that's when the problems came. They really didn't want to accept him at any kindergarten, at the schools. That really was a problem because everyone would tell me, well, there's the Special Education School, take him there. They'll accept him there. I would say, "how come, why, why does he have to go to a school for special education if he doesn't require any special attention, he simply can't walk." He thinks, acts, just fine. Really, sometimes you meet

people who offer you support and all. And so, he did attend a normal kindergarten; we bought him his little wheelchair and that's how we took him to kindergarten.

Then another problem was when he finished kindergarten and was going to start elementary school. The private schools would not accept him. I even had to bring something from the doctor who treated him, from a neurologist as proof that he had the benefit of all his mental faculties in order to study and learn. This then, was how they accepted him. Apparently, Huajuapan is still a small place where people are not used to seeing a child in a wheelchair; they are still in awe when they see something like that. And so fortunately, he started school and I think that for children it's much easier to adapt to their disability when they're still young than when they're already an adult. So then his classmates, well, in the beginning it was really hard for me the first time that I started him in elementary school. Maybe I thought about more things than him. Maybe I thought, "what are these children, the people, the teacher, my neighbor, what's everybody going to say? How can I take him like that in a wheelchair?" And perhaps I filled my head with more thoughts than he himself did. He was looking forward to it and really excited that he was going to be in school.

So, perhaps for his classmates, well, it might have been somewhat surprising to see a child like that in elementary school. But like I said, I think it's easier for children to adapt and get used to seeing their little classmate in a wheelchair. Really, I feel very, very happy and satisfied that now he is in school. All his friends like him quite a lot, help him, and he has adapted socially to his school. Like I said, now he's in sixth grade and fortunately has the support of the teachers as well as from us. Well really, I've always told him that what is most important to me is to support him in a way that he

will not face obstacles, that he not develop any complex, that he not have any complex or frustration. I want for him to feel completely normal--for him to do everything he wants to do.

There was one occasion that I remember very well when he must have been about seven, he asked me: "Mommy, why can't I walk?" "Well you see, you were born that way and sometimes it really isn't necessary for you to take big steps with your feet, I said, in order for you to do what you want to do. You can take big steps with your intelligence, with what you have in your mind, with your thoughts. In that way, you can take bigger steps than you could with your feet." That was my answer. And I think that when children ask questions, you should be clear so that you know how to answer them in those moments. Because I believe that those answers that we might give them at those times are more important for them; that those answers will be engraved in their minds and that those are the ones that are going to have the most value to them.

I really, well, it was very difficult in the beginning to accept that he was born with a disability. But I really think that if you have a desire to overcome, have a will to live and many other things, that you can make it. When you have the desire, you really can make it. That's my experience that I can tell you about from the point of view of a mother. I want to congratulate all the people with disabilities that are here and I want to tell you to really go for it in everything that you may want to do. Really. Thank you very much.

Aurora Sánchez González

Transcriber and translator: Joyce Y. García

Before we begin, I would like to congratulate each and every one of you for being with us here today. I feel that I too have certain disabilities though many people may say otherwise. I mention this because I feel certain insecurities. As I talk, you may notice that I'm nervous; I'm feeling insecure as I try to express myself with you. As someone else already said, I'm very proud to be the wife of a person with a disability. Why such pride? Because to me and to my children, he is a person of great worth. He is extremely valuable as a father and my children respect and admire him. There are many friends behind him who support and admire him; professional people like him. We as a family are very proud to know that due to his personal efforts, events like these are taking place. For him it's not just a matter of taking action, making proposals and consultation, or programs, it's also a matter of getting us going.

I greatly admire his ability to be, perhaps too kind, because he has received much, much, much negative criticism from some people who sometimes say: "But how can you be asking and doing so much for people with disabilities?" According to the government, the newscasts, television--all are saying that persons with disabilities are receiving support. "Why are you asking for support for people with disabilities? Look, you know what? Turn around, go away," with pretty words, you know. "We simply won't give you anything." I admire him because he never gives up. Despite the fact that many doors are closed to him, he's always looking for a way to make things happen--to show all those people who trust him and all those who are

at the forefront, because you should know that too, there are some people who collaborate and participate with him. Maybe without the help of all of them, it wouldn't be possible to do all this type of activity.

But I do remember that when I first met him, I didn't see him as a person with a disability. I didn't pity him as many people would say. Someone said it earlier, a person with a disability is not different. It's true, people with disabilities are not different. They are as normal and capable as anyone of us here. There's only one difference and that's physical. But if we were to stop and think a little about we ourselves being classified within the context of the disabled and if we were normal as we sometimes think and if we were to come before them and when we went to do something that they do, for example when they move their wheelchair, when they go upstairs with crutches, we would notice that perhaps we are the ones with many more disabilities.

Because who among us hasn't broken their foot, hurt our finger or a nail on our finger or toe and we don't even want anyone to touch us. And we don't want to do anything. Why? Because it hurts. And because we say, since I'm incapacitated with my little paper here to support what I'm saying, I'm not going to work. Because I can't walk because at work there are stairs so I can't climb them and since I broke my foot I'm not going to try to go to work. And how many people walking around in the streets or who go to work with the assistance of a cane or a wheelchair, some crutches, show up for work in order to carry out their tasks. I see that that influences parents as María Elena said earlier. That is, to make your children feel that security to be totally independent, to take care of themselves, to make something of themselves and to take giant steps even though they must rely on a pair of wheels, a pair of crutches, a cane, a prosthesis or whatever.

I did want to tell you about a time when Ovaldo and I were newlyweds. A light socket in one of the main bedrooms wasn't working. And I remember that just like any woman, I asked my husband for help because he was the one who was going to do those jobs that are sometimes difficult for a woman. And I was asking him to fix that light bulb for me and I noticed that he answered angrily. I don't know, to this day I haven't been able to understand that reaction, when he said to me: "How can you possibly ask me to fix that light for you if you can see that I can't?" If his reaction was to become angry and to tell me that he couldn't, imagine how I felt. It was worse. And why was it worse? Because I wasn't seeing him as a person with a disability. At that moment, the only thing that occurred to me was to say, "Well, I don't know how you'll do it, you get on a table, on a stool, a chair or a can, I don't know, but you fix that for me."

The discussion got worse because he was saying that he couldn't. At that moment, I was so angry, angry for being mistaken and not having seen how a normal person who could support me in good times and bad, and who was as capable as anyone else, and yet was there telling me "I can't." But I felt very proud an hour later when Ovaldo finally was bending over backwards to climb on a chair, he climbed on a stool and he leaned the step ladder against that and climbed up. Finally, he repaired the fixture for me. From that moment on, my admiration for him was even greater because I realized that even the greatest obstacle in the world, any one of you, not only him, can overcome.

Any one of you who wants to make it and to be above all human, those very things will bring you great results because it's more important to be human than to be normal. Here, unfortunately, the people here as well as other places are not used to interacting with persons with a disability because

they are afraid that if they come close, say hello or talk with them that they'll be contaminated. They don't ever realize that one way or another, they're in the situation they're in because of what happened a long time ago. That what you have isn't contagious and that we can extend a hand and interact with you and converse and learn a lot because the truth is that we learn a lot from each and every one of you--about how you think, how you act, how you make it in life, the enthusiasm you feel to move ahead and to be able to help everyone with whom you have contact.

The only thing I have left to say is to all the young bachelors who are attracted to a pretty girl. Well, Don Vicente over there has complained many times that no one pays any attention to him because he's in a wheelchair. Well get with it--get yourself your most handsome and flirt with a girl and maybe at this conference we'll get the news that you're finally getting married. Thank you.

Raquel Méndez Huerta

Transcriber and translator: Joyce Y. García

Good afternoon. My name is Raquel Méndez Huerta, daughter of a person with a disability. My experience is what happened to me at school. My father went to school once. There were a lot of people who were making fun of the fact that, well they said words that well, you don't like. The word was that he was a ----. He dragged himself. That upset me. It's something that you don't like. You don't like to get treated that way. I was treated really bad. I was always told the words that no one likes. I spoke with them that time. I told them, "No matter what he's my father. We're not always going to be complete." The little bit of knowledge that I had, I gave them answers. That time I told them: "Yes that's how my father is, I'm not ashamed of him, quite the contrary, I admire and respect him."

I feel very proud to be with him; I go places with him if it's necessary. I don't feel ashamed, quite the contrary, I have to help him ----. Neither of us criticizes the other or anything. If there are contradictions among friends or anything like that, we don't care. Quite the contrary, we see . . ., he's normal to us. To us, that doesn't, we don't care about that. So then, this little girl, I answered them, yes, angrily. If your father is whole, he has feet, hands, he doesn't take care of you, he abandons you, he isn't responsible in his household. He just goes around, he drinks, he doesn't work. I didn't answer the way I should have. Well I said, my father may be like that but he works, he's responsible with the family and not only that, he drives. Then the teacher found out and asked me questions. Is it true that your father can't walk. I said yes, he can't walk.

Once on the 14th of February, we had a party at school. On that occasion I said to my father, I asked him to get some fruit that each team was asked to bring. So then that was the day that I had the chance to introduce him to my teacher and I did. And she couldn't believe that he could drive. So we went, I introduced him and she was in awe. She was in awe that what I was saying was true and even so they ended up congratulating me and they felt, I mean that made me feel even more proud of my father and not to feel ashamed, but quite the contrary with my head held high. He gets around by dragging himself, but I have no reason to hang my head in shame, rather it's something . . . it makes me feel very proud of my father.

So there was another experience that was really something. I had to take a taxi. I left the business and the taxi driver asked me: "Do you work there?" I said yes. He said, "Oh, you work with the little crooked man." I said, I work there but that man is my father. ---- He said, "I'm sorry." Oh, that's okay. So then he started to say: "But how does he do it, because the way he is, he can't walk. He has three businesses. The rest of us are whole; we have feet and hands and we can't make it." I told him: "Look, he manages because he makes a big effort. He worked hard to ----. He accomplished what he set out to do." I mean, it's not that it's impossible, rather they just don't sit down and don't do anything and ---- their talents. What he's done, he's been able to do because he's made such a big effort. He accomplishes whatever he sets out to do and that's something very, very special for us and we're very proud of him.

So then the man said to me: "Okay, you talk about your father as though you're very proud of him. I congratulate you that as a daughter, you're not ashamed of him." I told him: "Of course not, quite the contrary." We help him and don't have any reason to feel embarrassed." He says:

"Okay." Then he said the word "**sick**". I said: "No, he's not sick. It's simply that when he was very young he had a sickness. Then he stayed that way but that didn't stop him. He was able to take advantage of many things, face many, many, many obstacles that got in his way. And by making such an effort, he was able to meet all the goals that he set for himself. To me, that's nothing to be ashamed of or anything.

If there are other colleagues here who have children, I think they must feel the same way and they must feel proud of their parents. Though what they've done may be small by comparison, it's enough as long as the basic needs for the home are met. And something else. I would just like to tell the young people, the children of the adults who are here. Don't feel ashamed, you never know. Right now we're whole and tomorrow, who knows. None of us knows when something might happen to us. We're not always going to be like this. We shouldn't reject them, on the contrary, we should talk to them and help in any way we can. And that's a lot, a lot for them.

Above all, as a daughter, I'm very proud of my father for what he's done. And I also think that other children of people that are here must also be proud of their parents for what they've done for them. That they didn't give up ----, no, it's quite the contrary they too have to help to encourage others so that they too can make it in life. Well, that's all I have to say, but it's something that I said because I feel great pride. And well, the only thing I have left to say is to go forward and take courage so you aren't left behind. That's all. Thank you.

Appendix I

First Congress Regarding Disability in the Mixteca: Roundtable Discussions and Recommendations

First Congress Regarding Disability in the Mixteca
Roundtable Discussions and Recommendations
Disability and Society

Transcriber and translator: Joyce Y. García

Disability and Society

[This roundtable consisted of] Lorenzo Machaca Menza, Marcos Hernández, Vincente Salazar, Germán Pérez Cruz, and myself [Jorge Pineda]. We started by determining that there are many problems in society in relation to discrimination toward us. So, in our roundtable, we were saying that we would like to set up a system of raising awareness for society--to educate society. We would like to do the same for the authorities and all people with whom we might have dealings such as businessmen, administrators in the area of education and health, etc. And we have some suggestions here. You will have to pardon me, I have not had time to put them in order. I will probably make some mistakes, please forgive me. We began with the idea that we could form groups that would go to various authorities or to the people who we have to work with in order to talk with them. There are some suggestions about when the authorities say, "I don't have time, that's a person with a disability, I don't want to talk to that person, I'm not interested, etc." We decided that we should insist and perhaps if this person is really busy, which could be because of their work hours, invite them to coffee or meet for lunch so you can visit more comfortably away from the office. That could be an option.

We also talked about changing attitudes. We feel things should be done in writing. We think it's more formal and besides, you can keep a record of what's being done in the group. We also agreed that when a particular authority doesn't pay any attention to our requests, then we should go to a higher authority than that person until someone does pay attention to us. That is, don't give up just because someone said "no" to us; we shouldn't give up. We must always go to a higher authority than that person until someone listens to us.

There were also some comments that in between the campaigns for raising awareness that we let people know that we don't want pity, that we're human beings. We would like to raise the consciousness of young people so that they don't offend us and don't mistreat us because there was a comment by one of us, I think it was Miguel who said that young people make fun and mistreat us. At least he has had that experience.

We spoke about the fact that one of the ways of changing society, our culture, is through some alternative forms such as doing more conferences like this one, roundtables in which we involve everyone: authorities, businessmen, the health and educational sectors, and others in general. We also spoke of making announcements to always publicize and inform by any means, and if possible all the media, about all the advances the Association makes. The publicity should be constant so that people will always be informed about what we're doing.

We talked about the research work that was reported on yesterday and feel that it should be completed as soon as possible. We also feel that there should be more [research] and that we should go to the most poor rural communities in order to broaden the study that has already started. We would really like this done for the [indigenous] communities that do not

speak Spanish. Also, make the results of this conference known to all of society in general, all the authorities, etc.

We should also do a consciousness-raising campaign so that people won't park in the places reserved for persons with disabilities. Let's do a campaign so these people won't park there. There was even a comment by one of our colleagues that even the police park there and that's really bad, but well, we should also make the police aware, right?

We should amend the law on disabilities in Oaxaca as necessary in order to correct errors or things that were omitted, or things that weren't contemplated in the law in the first place. They then can modify or broaden the law. And finally, in order to wrap up, we spoke about forming commissions in order to educate, train, and advise public as well as private authorities, businessmen, society in general, etc., everyone with whom we have contact. And briefly, those are all the things we agreed to.

Women with Disabilities

My name is Victalina García López. My group dealt with women with disabilities. The needs expressed were: (1) lack of education and employment, (2) lack of orthopedic devices, and (3) lack of wheelchairs in order to move about. The problem regarding transportation was in reference to time constraints given family/work responsibilities. The women are locked in even by their families and other responsibilities; they have to see to the well-being of people such as the children and parents.

Recommendations:

1. Establish open educational (adult education) opportunities to complete elementary school within the same time frames as training for work.
2. Vocational training enabling the women to work.

3. Talk about the needs of each one of the women with disabilities, but also to acknowledge and focus on the capabilities of each of the women with disabilities.
4. Attend a conference for women with disabilities in Oaxaca.

Vocational Rehabilitation

Hello, good morning. Our work group was called Training and Employment. We all agreed to call it vocational rehabilitation. The people in the group were Manuel Acevedo López, Leonor Quiroz Cruz, Eddie Cortez Quiroz, Nicasio Méndez Pérez, Jorge Huerta Campos, Federico Santiago Ríos, Joaquin Efigenio Arias, and Aurelio Jímenez Rodriquez. . . . We began with the presentation of our colleagues who talked about disabilities. Among them, Aurelio Jiménez Rodriquez had had problems getting work and through the different presentations, we came to a conclusion in which we agreed to create a micro-business for persons with disabilities here in the Mixteca region. Beforehand, we want to have a survey and classify people who require employment in accordance with their disability as well as their ability.

We want this business to be led by a person who has a disability; those who have a disability can understand one another better. Different workshops could give vocational training by people who have experience in that field. [With training] we could demonstrate that we are people with disabilities who are capable of doing many, many things. A person should be given the opportunity to demonstrate to society that we are capable persons. I think we have examples here, examples in Huajuapan, of persons with disabilities who have succeeded and who can be an example to everyone else.

We had another idea which was the silk screen workshop since there could be a high rate of sales and there are great marketing opportunities in Huajuapan. That's a very general idea of what we discussed.

Health

[Presented by Dr. Raúl Guzman]. First of all on behalf of the Office of Public Health and Hospitals of this city, I would like to thank the group, the Association of Persons with Disabilities for the Mixteca Region for the opportunity to participate with each and every one of you. In our group, we were saying that really what we dealt with at this table was not so much the participation of the people but rather the understanding of the Health Sector. Once again, I'm going to take this opportunity in the name of the Office of Public Health to express my appreciation and indicate how our health system is structured. This is to be able to understand better what participation the health sector has with regard to their group. And how with all of this, it is understood the Association of Persons with Disabilities has been developing for some time in different places here in our city. So, I'm very pleased to know that it continues to develop, that this is the first conference in other places of the republic and in other parts of the world. These groups have already been established and there are guidelines and criteria and the people are prepared to provide things for you but more than that, make your rights available to you. The definition of a person with a disability is one who has a physical limitation which doesn't allow them to do certain things. I don't think this is a serious barrier because there are ways in which this barrier can be overcome. Just because someone has a physical disability doesn't mean they have to remain isolated from the rest of society. By coordinating our efforts, we can make it. My specific objective and interest in being here with

you is to inform you about our purpose and about what the health sector can offer each one of you. First of all, I'd like to tell you about the structure of the Office of Public Health in spite of the fact that we already have instructions in place and several of the hospitals have implemented the programs; that is, the programs are being publicized as well as being supported. The support that the hospitals are providing, first of all, is access to the hospitals. What's being done at the hospitals? At several hospitals in our state, there are already access ramps. The hospitals have plans to build ramps. Obviously, I'm not offering this as an excuse because we haven't done it yet. The plans are in place and they're being carried out due to the budget and the resources that we receive at the state level. In terms of structure, as I already mentioned, the Office of Public Health in the state of Oaxaca has medical assistance communities in each of the municipalities, in each of the towns and to that end, the health sector provides care at three different levels.

The first level of care in the community is through clinics, health care homes, and health care centers. The second level comes through hospitals, hospitals with thirty to sixty beds. Our Mixteca region has two hospitals, one of which is here in the city of Huajuapan de León. These hospitals each have thirty beds. The one here in the city is a general hospital located at the international highway, Carranza Number 64, and the other is in the city of Cutla de Guerrero and each of them has the same number of beds. The third level is in the Oaxaca City which is the hospital, with the support of two hospitals, one specializes in oncology and the other psychiatry. It's very important that you know that the structure because what we offer you will depend on that. We can't tell you that we're going to offer you third level care if we don't have it. The reason I feel that this is important for the health care system to be clear is because in our work group we talked about the fact

that some of you are in the city but others are in the rural areas. So what we propose and offer you from our work group is health care at the primary and secondary level for this region. The third level will be limited to the Oaxaca City but we can support you in terms of prevention and treatment. This arises because we were asked about rehabilitation which is the major thing that you suggested to me in our group. Unfortunately for us, we do not have the means nor anyone with training who would be able to provide care at that level. But care at the primary and secondary level--I don't think you have any problems, state directives indicate that those services will be provided for you. We talked about the quality of that care in our group. How will we provide those services? I've received correspondence from the Office of Public Health with instructions that those services be provided at no cost to you. Also, that you should have the same access as any normal person. I see no difference in this policy in cases of illness. As a matter of fact, since you're have disabilities, it doesn't mean that you're exempt from any pathology. You can have problems with diabetes, hypertension, or cardiac problems. So what we try to do is to provide quality care and that quality care will be accomplished when you and your Association representative work together and work in conjunction with each of our health care centers. That's how it works in terms of structure. Now I'll go on to the objective which I had already mentioned. It is total care, which I had also already mentioned. We'll have to accomplish total care in accordance with what we have available at our hospital. As you all know, our hospital has thirty beds. We also have the four basic services which are internal medicine, surgery, gynecology, and pediatrics. These basic services have eighty percent coverage in terms of specialists and we also have a specialty which I think will be helpful to you and that is orthopedics and traumatology. Unfortunately, we do not have the

technical resources to offer that specialty as completely as we'd like. Our orthopedic specialist does all he can in cases of accidents and traumas due to violence when these kinds of cases come in. Why? In order to provide proper recovery. But there are times when we are limited by the material or equipment necessary in order to provide pins, plates, prosthesis, all those things are quite expensive and our region cannot respond to these needs. We're not prepared. We don't have the proper financing for these kinds of resources. So in our work group, we were saying that in order to offer this type of care to all of you, we need to work together. It's already been said, we'll work with you directly by coordinating with your president. That was one of our conclusions. Furthermore, I would like for us to make it a priority, to emphasize what I think is very important and affects the five work groups and that is education. We need to be educated in order to know how to use the health services--when we'll have access to that service and how to use it. I gave the example of urgent care. We have urgent care services with a specialist available 24 hours a day. We all know there's a great demand for that. I'm asking everyone to help in one way or another, by participating, educating our people, educating them in that we must respect these rules, certain guidelines and know how to value what we have and use appropriately. Urgent care is for all of you no matter if you have a disability or not, have insurance or not. Our hospital provides urgent care for all people no matter if you're a child or an adult, rich or poor, there's no distinction in our hospital because it's for the public in general. So whenever you need urgent care I would like you to take advantage of this service which is available to you, at least that's my intention. Now whenever you require service in the area of the four basic services, your president and I will coordinate it. That way, all the services we have available will be offered in a

more objective and more clear manner and without any cost to you. We also discussed that our hospital offers you quite a lot but you must know how to use the services. You do have to know how to use the services. By that I mean that we cannot do an exam on each one of you though that is essential and proper; we cannot provide a monthly or weekly exam to know the condition of your health. But we cannot do that, why? We have few resources--they are few and the demand is high. There's a great demand. We serve the entire Mixteca region. I think it would be wise for us to determine how frequently or what priority we give these services. All the specialists are going to strive to establish independent rehabilitation services. I would like to invite the president so that we could agree on a rehabilitation plan, which I think is handled by [UI] here in [UI] where the housing or something like that is. So we should see in what way we could support or offer help because that's why we have a specialist and a physical therapist so they can be in charge of this unit. We cannot improvise things. So then it is important that you become part of the hospital if you will. We'll try to see to it that urgent cases be handled directly by management so that we can educate people. I personally make a commitment to you to talk with the doctors and initiate them regarding providing better services for you. Yet we must always have an order, we must always cooperate among us and then there won't be any problem. We're going to make it, because I, as a matter of fact, think that you're people who work and make things happen and I think that's because you understand each separate function. So you, I don't think you're, a person with a disability faces obstacles and gets looked down upon as I was saying before. I think it's time we recognize you and give you the attention you deserve as long as we work together so that we don't end up misusing the services. That's all I ask on my part and I think that once again I congratulate

you for this organization and I think it should continue to grow not only in what you do but also in numbers. Remember that our region is not only Huajuapan; we have areas that are hard to reach. We must try to reach them in order to offer support to them also just as you're showing support for the health sector by inviting me here. We have to emphasize other areas too. By working together, your group with the support of our institutions, we can make it and that's a given. We just need to be realistic and make sure that it happens. I came away from this work group with many good impressions from all of you, children as well as adults. We have pediatricians who can be supportive and I think this is the best way to understand each other, to help each other and to collaborate for your benefit as well as for the benefit of our region and our country. I think that's the best we can do--by working together we'll make it.

I want to congratulate you once more and I also want to thank you for inviting me to the work group. I think that we'll put what I learned into practice. I want you to know that the hospital is here to serve you. Thank you.

Education

The round table in which I participated was about education. It was a small group, formed by the citizen Michele de Espindola, the citizen Juan Arelí, and myself, Laura Morales. We agreed that education . . . well a few minutes ago the doctor was already talking about education and education is important for every human being, for every living soul. Education is learning and teaching in our daily lives and should be permanent. There are two types of education: formal and informal. Formal education is that which is taught in classrooms and institutions, and informal education is what we

learn by participating in society itself. First, education should be part of family life, education should happen within the family so then it can happen in society, in the workplace, and in order to have mental freedom.

We also presented other points of view such as how it is different for children with a disability to integrate themselves into society. Children adapt easily to society. Why? By the simple fact that children have their normal development, then there are no barriers in the child. Yet in adults, they may exist. However, all of this will depend on education. In an adult, many times barriers could exist when by misfortune an accident occurred and leaves one with a disability. In an adult, barriers exist such as, "Now what will I do," but many times one will overcome them only through education.

One of the propositions we made in the group is to ask for or demand of formal education that it create the infrastructure and legal framework that allows the development of the society in terms of education, since it is essential in the lives and development of the people.

ISBN 1-888357-71-0

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